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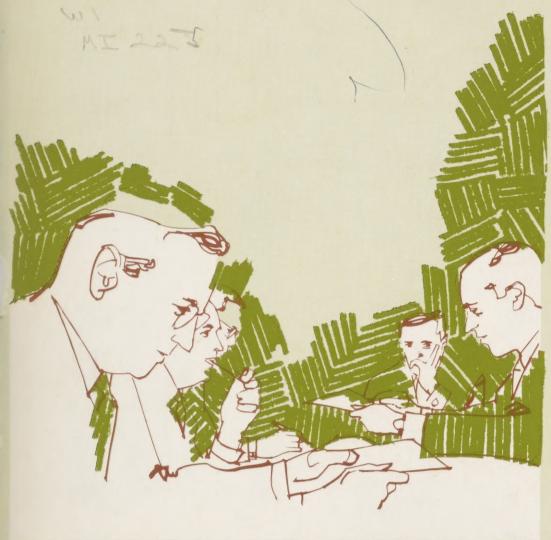




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Block out October 1 and 2 and participate in the 1969 MSMS Annual Scientific Session in Detroit. The Scientific Program Committee is completing its work now selecting timely topics and inviting recognized authorities to speak at the general sessions, specialty meetings and concentrated one-day courses.



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MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

JULY 1969

VOLUME 68

NUMBER 13



MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

JULY 1969 • VOLUME 68 • NUMBER 13

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ANNUAL SCIENTIFIC SESSION, OCT. 1-2

House of Delegates Committees Work To Complete Reports for Sept. 28-30

A full year of work goes into the making of a Michigan State Medical Society Annual Session — this year's is scheduled Sept. 28-Oct. 2 at the Sheraton-Cadillac Hotel in Detroit.

Committees, the MSMS staff, individual doctors and even out-of-state physicians who will be giving presentations spend months preparing the five-day meeting which annually attracts thousands of doctors of medicine, wives, residents, interns, nurses, medical assistants and other interested persons.

The MSMS Annual Session will follow the pattern developed in 1968. The House of Delegates will convene Sunday night, Sept. 28 and continue in session all day Monday and Tuesday. The Annual Scientific Session, with national authorities discussing timely topics, will follow on Wednesday and Thursday, Oct. 1 and 2.

House of Delegates Committees and their chair-



men are the Single Medical Practice Act committee, F. S. Gillett, M.D., Grand Rapids; Medical Staff Survey of Hospitals, Rosser L. Mainwaring, M.D., Dearborn; Professional Liability Insurance, John G. Slevin, M.D., Grosse Pointe Park; Certificates of Commendation, James H. Tisdale, M.D., Port Huron; Constitution and Bylaws, Robert S. Ideson, M.D., Ann Arbor; Financial Structure of MSMS, Charles W. Oakes, Jr., M.D., Harbor Beach; Selecting Michigan's Outstanding Physician, John W. Henderson, M.D., Ann Arbor; Proceedings of the House of Delegates, Noyes L. Avery, M.D., Grand Rapids, and Compensation for Officers, John J. Coury, M.D., Port Huron.

Among the active committees are those working on the Single Medical Practice Act and on Professional Liability Insurance.

The Single Medical Practice Act committee researched and drafted the bill, and arranged for it to be introduced in the Michigan Legislature. The proposal was explained at a large MSMS news conference Feb. 20.

A key move by MSMS to improve the standards of health care, the bill calls for one set of standards and one examination for both MDs and DOs under a single state licensing board which would grant licenses in both medicine and osteopathy. The bill is still alive for legislative action this fall.

The Committee on Professional Liability Insurance has been reviewing in depth the spiraling increased costs for such insurance, a problem that is national in scope. The committee is considering solutions and will make formal recommendations at the House of Delegates meeting.

Other House of Delegates committees that have been active include the Certificates of Commendation Committee and the Committee to Select Michigan's Outstanding Physician. Both have sent out nominating petitions and will soon select candidates to be considered at the House meeting.

A more detailed Annual Session program will be printed in the July News Extra.

JAMA's Advertising Policy Brings Muskegon MD's Criticism

The AMA has a policy of accepting for its Journal advertising promoting commercial laboratory ventures. The policy has brought criticism from around the country, such as this letter by a Muskegon pathologist to the MSMS Publication Committee. Comments Brooker L. Masters, M.D., committee chairman, "The letter poses an interesting philosophical dilemma and would be good to read before the AMA meeting."

The appearance of a back cover advertisement in The Journal of the American Medical Association for April 21st offering the Clinical Laboratory Services from the Upjohn Company caused me to immediately write a letter to the Editor of that publication.

As a clinical pathologist and a member of the A.M.A., I am chagrined to find that the Journal accepts such advertisements for commercial laboratory ventures. The Director of this Upjohn Laboratory Procedures Division is a lay person, and those of us in clinical pathology have cause to regret further support by our colleagues of laboratory operations not actually directed by pathologists or other physicians.

Dr. John H. Talbott, Editor of the J.A.M.A., has indicated that acceptance of such advertisements was the decision of the Board of Trustees, and since considerable objection to this policy has already been raised, it will surely come up for discussion at the House of Delegates meeting in New York in July.

As advised by Dr. Talbott, I wish to register my objection, through the Michigan State Medical Society, to this policy as established by the Board of Trustees of the American Medical Association. I feel this policy furthers a cause that is detrimental to the practice of medicine in general, and to the practice of clinical pathology in particular. This is a current problem among pathologists, between pathologists and other physicians, and between both and hospital administrators.

Dr. Dwight L. Wilbur, A.M.A. President, has been quite recently quoted (A.M.A. News, April 21, 1969) in speaking about the A.M.A.

"It is the one medical organization already established, already functioning, that embraces every physician regardless of his medical specialty, his scientific interest, his career function or his socio-economic point of view."

"Problems and solutions in any one specialty must be coordinated with those of all the other specialties and with those of medicine in general."

If the A.M.A. is, in fact, to represent the specialists within the membership as well as the interests of medical practice in general, this is one area to which the officers could give their attention.

Thank you for your consideration of this matter.

Sincerely, Thomas Kelso, M.D. Muskegon

DOCTOR JAFFAR LEADS NATION'S UROLOGISTS

Donald J. Jaffar, M.D., South-field urologist, was installed as

president of the American Urological Association at the organization's annual meeting late in May in

San Francisco.

Doctor Jaffar
is clinical professor and former acting



Doctor Jaffar

chairman of the Department of Urology at Wayne State University School of Medicine. He and Mrs. Jaffar will be honored guests at the annual meetings of the eight sections of the American Urological Association, the Canadian Urological Association and the Pan American Urological Association.

State Employes' Health Plan To Be Released

All county medical societies will soon be receiving copies of the new state employes' health maintenance program, prepared by the Michigan Department of Civil Service.

The program, with John A. Cowan, M.D., medical director, includes the Civil Service Commission's plan to implement multiphasic screening tests under the already existing state contributory health insurance program.

The screening examinations will serve to detect so-called hidden diseases, develop and educate persons to the necessity of a health maintenance program, serve as an epidemiologic tool and provide a vehicle for feasibility and demonstration studies.

A more complete report, prepared by Doctor Cowan, will appear in the August issue of *Mich*igan Medicine.

Basic Science Repeal Decision Postponed Until September 10

BY M. A. RILEY
MSMS LEGISLATIVE COUNCIL

House Bill No. 3098, which in a single sentence repeals Act No. 59 of the Public Acts of 1937 (the Basic Science Law) has been "tabled" by the House of Representatives until the session reconvenes on Sept. 10. At that time a simple majority of the House members present can vote to remove the bill from the table, and 56 affirmative votes will pass it and send it on to the State Senate.

The House Public Health Committee, William Fitzgerald, Chairman, considered the bill and recommended that the House pass it on June 12. Unfortunately, at the time the subject came up in its order on the House agenda, 20 members (many of whom would have supported it) were temporarily absent. As a consequence, the bill only mustered 42 of the 56 necessary votes.

The bill's introducer, Rep. Phil-

PCHA REPORT REVEALS PLANS FOR HEALTH UNITS

The southeastern Michigan Peoples Community Hospital Authority (PCHA) has recently issued a 77-page report that was 17 months in preparation.

The report reveals population pressures on PCHA hospitals and indicates the directions in which the authority will have to move by 1980 in order to provide adequate health care services for its participating communities.

The report includes detailed appendices for each PCHA hospital unit and information about the service area of each unit. It was presented formally at a June 19 PCHA board meeting. Karl S. Klicka, M.D., Detroit, is PCHA executive director.

ip Pittenger, assisted by Rep. J. Bob Traxler, were successful the following day in resurrecting HB 3098 and having it "tabled" so that it would be in position for another attempt at passage in the early Fall.

MHC STRONG SUPPORTER

Strong support for passage of HB 3098 came from the Michigan Health Council, which presented telling testimony before the House Public Health Committee including actual correspondence from physicians who have been deterred from practice in Michigan by the obsolete law. Mr. John Doherty, Executive Secretary of the Council, also pointed out the fact that doctors of osteopathy and chiropractors, both of whom are required along with medical doctors to satisfy the Basic Science requirement, are meeting that requirement by reciprocity with other States (there being very few schools of either osteopathy or chiropractic). In fact, said Mr. Doherty, in 1967 only nine osteopaths and no chiropractors took the Basic Science

A majority of the House Public Health Committee, led by Rep. Fitzgerald, supported repeal of the

MSMS EDITORIAL REPRINTED

A large portion of an article from the December, 1968, issue of Michigan Medicine was quoted in the June issue of the Journal of the Medical Association of the State of Alabama.

In an editorial the Alabama magazine noted that "it is interesting to go back to last December's issue of *Michigan Medicine* and reread an article titled 'Nixon's Views on Medical Issues.' Without further comment, a large portion of the article was then reprinted.

bill. Although 42 Representatives supported the repeal, 48 opposed the bill and a survey of the twenty absentees indicates that a second vote in September will be extremely close.

MORE PHYSICIANS ECONOMICALLY

As MSMS has pointed out in statements through the Michigan public press, repeal of the Basic Science law, which would cost the taxpayers nothing at all, could result in the acquisition of more new physicians for Michigan communities each year than the number of entering students cited for a proposed osteopathic college, students who would still be five or more years away from practice.

All Michigan State Medical Society members are therefore urged to discuss with their State Representatives, during the Summer recess of the Legislature, this very practical means of doing something positive and immediate about reducing the critical physician shortage.

To Medical Libraries On 'Michigan Medicine' Mailing List

"Will you please send us Vol. 67, Nos. 4, 8, 10, 12 . . ." comes the letter from the Emory University Library in Atlanta, Ga. It is typical of many requests received at MSMS headquarters from archives around the nation and world who have misplaced or lost issues of Michigan Medicine.

The even-numbered issues are the blue News Extras published mid-monthly. The staff of *Michigan Medicine* urges all medical libraries to file and bind News Extras along with the larger monthly journals, so that records will be complete.



MD-PAC Plans Two Events: Breakfast Oct. 1, Workshop Nov. 1

The Michigan Doctors Political Action Committee (MD-PAC) announces two major events on its calendar this fall.

The Annual Congressional Breakfast will be staged at 7:30 a.m. Oct. 1 at the Sheraton-Cadillac Hotel in Detroit and the Political Workshop is set from 10 a.m. to 3:30 p.m. Nov. 1 at the Lansing City Club, Jack Tar Hotel, Lansing.

The MD-PAC Breakfast, which is scheduled during the MSMS Annual Session in Detroit, will feature talks by two Michigan congressmen, representing both major parties. Chairman is Louis R. Zako, M.D., Allen Park.

On his committee are George Reno, M.D., Detroit; Jack Stack, M.D., Alma; William Zimmerman, M.D., Grand Rapids; Frank Bicknell, M.D., Detroit and Frederick W. Engstrom, M.D., Dearborn, along with Mrs. Willah Weddon, Stockbridge, of The Woman's Auxiliary to MSMS.

The Political Workshop Nov. 1 will kick off Medicine's 1970 political campaign and emphasis will be given to political education technique and organization. Official representatives of each political party will be invited to speak.

Chairman is Doctor Stack. On his committee are Doctor Zako; Thomas Berglund, M.D., Kalamazoo; William O. Mays, M.D., Detroit, and Robert Jardinico, M.D., Saginaw.



MSMS President James J. Lightbody, M.D., right, is pictured with executives of the State Medical Society of Wisconsin, who invited Doctor Lightbody to their annual meeting late in the spring. From left are J. W. McRoberts, M.D., Sheboygan, Wisconsin president-elect, and R. E. Callan, M.D., Milwaukee, president. Doctor Lightbody was present for the Wisconsin Society's House of Delegates meeting and he and Mrs. Lightbody attended the annual dinner.

Detroit Youth In New Health Program

Forty members of the Medical Careers Club of Northwestern High School have been selected by the Michigan Health Council to spend six weeks from June 30 to Aug. 8 in a Summer Exploratory Experience Program in Health Professions.

The youngsters, all recommended by science teachers and guidance counselors, will spend three hours daily in class at Northwestern High learning communications skills as they relate to health professions, seeing new health films and hearing special presentations by outstanding health leaders of the state.

An additional three hours each day will be spent in hospitals assisting all the related health professionals at work there in eight of the hospital departments. They will have an opportunity to observe minor surgical procedures and will also spend a full day at Michigan Blue Cross-Blue Shield.

The unique program, first of its kind in the nation, is funded by the Chrysler Corporation Fund, sponsored by the Detroit Medical Society and developed through the Detroit Commission on Children and Youth, the World of Work Program of the Detroit Public Schools and the Health Council.

C. Dale Barrett, M.D. To Head Coldwater Facility

The executive director of the Wayne County Comprehensive Service for pre-school, school and adolescent children, C. Dale Barrett, M.D., Detroit, has been named superintendent of the Coldwater State Home and Training School. His appointment is effective July 7.

Doctor Barrett succeeds E. J. Rennel, M.D., who retired.



JAMES J. LIGHTBODY, M.D. PRESIDENT, 1968-69

It's !Fantastic

Over a period of three years many new expressions or words have developed to replace the so-called time-worn verbiage associated with descriptive ideas. These expressions are not really new, but are substitutes for thoughts injected into our speech jargon to either evade the truth or to further identify with vagueness.

Take the three words — "sophisticated" — "dialogue" — and "fantastic" — that are currently being kicked around and used indiscriminately when there is an acute shortage of relevant insight into any subject. We have "sophisticated approaches" — "sophisticated systems" — "sophisticated plans" — and "sophisticated variations" — ad infinitum. Sophistication often reflects ignorance and implies a depth of knowledge where there is none.

We used to have conversations with certain people regarding certain subjects — now we have to have a "dialogue" — which is mathematically equal to two or three monologues. The word "fantastic" is probably the most over-worked of all the various and sundry excess verbal mannerisms — but it does have an explosive fantastic sound.

MANY OTHER EXPRESSIONS have crept into our national diction and often cover up the intended meaning. Poor people are no longer called "poor," but are referred to as "economically and culturally deprived" and children with mental retardation are now termed "exceptional." Kindergartens are now referred to as "early learning cen-

ters" – and libraries have become "instructional materials resource centers."

The poor may also be referred to as "underprivileged" – "disadvantaged" and "economically deprived" – but no reference is to be made to their main characteristic and common denominator, namely – they don't have any money!

Children who disrupt classrooms are termed "emotionally disturbed" and are promptly referred to a psychiatrist. The teacher or principal of the school used to take care of these cases in an appropriate manner, but these days we must consider that all children are dear and sweet and tag them with terms of psychiatric endearment.

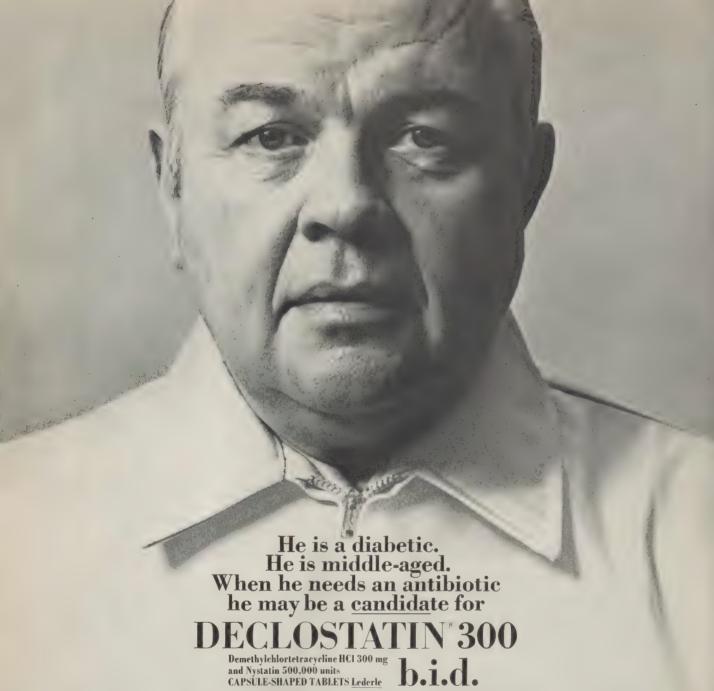
Another area where there is an over-abundance of pseudo-intellectualism is among government workers who invariably take an "over-view" of every problem — then do an "in-depth" analysis using the "multi-disciplinary approach." "Decision making" has various "matrices" that are frequently "conceptualized" and "computerized" after investigating all "parameters" — and don't forget that every experience and action must be "meaningful."

PHYSICIANS OCCASIONALLY USE pseudoscientific expressions in describing physical ailments to patients and some patients remain in an aura of ignorance even after the physician has described the exact name of the disease, such as — "hypertrophic pulmonary osteoarthropathy."

We hope the medical profession will continue to explain physical ailments to patients in terms that they can understand and avoid participation in the current evasive jargon of the pseudointellectual.

James J. Lightbody, M.D.





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Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photo-allergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system-anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin-maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney-rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions-urticaria, angioneurotic edema, anaphylaxis. Teeth-dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given I hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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INFORMATION

FOR CONTRIBUTORS

- 1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.
- 2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size $(8\frac{1}{2} \times 11 \text{ inch})$ paper.
- 3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits
- 4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.
- 5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by Michigan Medicine. Michigan Medicine will pay the first \$25 of the engraving bill, and the authors shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.
- 6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.
- 7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.
- 8. Articles should ordinarily be less than four printed pages in length (3000 words).
- 9. References should conform to *Cumulative Index Medicus*, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.
- 10. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.
- 11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
- 12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

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Michigan Medicine

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All Michigan physicians early this spring received a letter (printed first, below) from the Michigan Optometric Assocation interpreting the AMA Judicial Commission's recent statement on physician referral of patients to optometrists. According to John W. Henderson, M.D., president of the Michigan Ophthalmologic Society, the Optometric Association's letter "slightly distorted" the AMA stand. His letter clarifying the issue is also printed (right) along with the AMA Judicial Commission's original statement (in box). All are published at the direction of The MSMS Council, to inform Michigan doctors of the facts.

Doctor Henderson Clarifies AMA Stand On Referral of Patients to Optometrists

Letter from Optometrists:

Dear Doctor:

We know it is extremely difficult these days to keep abreast of all the correspondence and publications which cross your desk. That is why we are writing this letter.

We believe the Judicial Council of the American Medical Association has taken action which is of unprecedented significance to the professions of medicine and optometry and that it is to the advantage of both professions that information concerning the action be disseminated to as many practitioners as possible.

The action concerns the Judicial Council's recent statement that a physician may send his patient to a qualified and ethical optometrist solely for optometric service.

The statement, which was published in the August 5, 1968 issue of the AMA News, expanded a previously adopted opinion of the Judicial Council regarding relationships of physicians and optometrists (as published in the December 26, 1966 issue of the AMA News) which declared optometry not to be a cult and stated that an ophthalmologist may employ an optometrist to assist him, provided the optometrist is identified as an optometrist and not as a doctor of medicine. In the same



OPINION OF THE JUDICIAL COUNCIL (June 15, 1968)

Question: Is it ethical for a doctor of medicine to refer his patient to a qualified optometrist solely for optometric care?

Answer: In the opinion of the Judicial Council a doctor of medicine may send his patient to a qualified and ethical optometrist solely for optometric service. The physician would be ethically remiss, of course, if before doing so he did not insure that there was an absence of any medical reason for his patient's complaint, and he would be equally remiss if he sent a patient without having made a medical evaluation of the patient's condition.

opinion, the council said a physician may teach in recognized schools of optometry.

We of the Michigan Optometric Association are most anxious to cooperate with you in providing professional optometric care for your patients who may have vision anomalies. In turn, we pledge our complete cooperation in referral of patients from our offices whose pathology indicates a condition which should be corrected by medical procedures.

In an age when the shortage of professional health care practitioners of all categories is acute throughout the nation and when the need for professional care has never been more required, it is indeed gratifying to learn of the informed and responsible actions of the Judicial Council of your professional association as outlined in this corres-

May we also take this opportunity to wish you and your family a new year filled with happiness and good fortune.

> Most cordially, Jack F. Hill, O.D. President Michigan Optometric Association

Letter from Dr. Henderson:

County Societies Committee Michigan State Medical Society

Gentlemen:

You have before you a copy of the letter of January 3, 1969 which was mailed to all the physicians of Michigan by the Michigan Optometric Association. This quoted the action of the Judicial Council of the A.M.A. incompletely and openly solicited the referral of patients to optometrists by members of the M.S.M.S.

By correspondence from other states it is evident that each state organization was advised to send such a letter by recommendation of the American Optometric Association and many have done so.

Although the optometric groups have a right to send such correspondence, the Michigan Ophthalmological Society views this as a continuing effort to equate the optometrist and the ophthalmologist in the minds of the medical profession as well as the lay public. The physician who refers his patient for "professional optometric care" should not assume that a complete eye examination has been performed and should be well aware that the majority of medical conditions may neither be properly assessed nor even recognized.

In particular, the sentence in paragraph 4— "we pledge our complete cooperation in referral

of patients from our offices whose pathology indicates a condition which should be corrected by medical procedures . . ." bothers us. It infers that pathology will be diagnosed, and a referral based on the judgment of the optometrist as to whether treatment is indicated. This to us is the practice of medicine for which the optometrist is neither trained nor licensed.

Although we believe that there is a definite place for optometry in meeting the needs of the public, we object strenuously to any effort which is made to equate optometry with medicine. We believe that a *full* presentation of the latest A.M.A. Judicial Council ruling with an appropriate covering letter should be mailed to all members of the M.S.M.S. explaining that any physician who refers his patient to an optometrist for refractive care should retain responsibility for the medical care of the patient, and that diagnosis of disease is not within the legal province of optometry.

Sincerely, John W. Henderson, M.D. President, Michigan Ophthalmological Society

Michigan Mediscene

- July 2 Michigan Association for Regional Medical Programs, MSMS Headquarters, East Lansing, 1 p.m.
- July 13-17 American Medical Association Annual Meeting, New York City.
- July 21 American College of Emergency Physicians, MSMS Headquarters, East Lansing, 5 p.m.
- July 24-25 Coller-Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City.
- July 26-27 Michigan State Medical Assistants Society Summer Seminar, Mackinac Island, The Grand Hotel.
- July 31-Aug. 2 Midsummer Session of The Council, Boyne Mountain Lodge, Boyne Falls.
- July 31-Aug. 2 Midsummer meetings of Medical and Health Organizations of Michigan, Boyne Mountain Lodge, Boyne Falls.
- Sept. 15-16 29th Annual AMA Congress on Occupational Health, Stouffer Riverside Inn, St. Louis, Mo.

- Sept. 28-Oct. 2 Michigan State Medical Society Annual Session, Sheraton-Cadillac Hotel, Detroit
- Oct. 1 MSMS Council, Sheraton-Cadillac Hotel, Detroit.
- Oct. 8-11 Twelfth National Conference on Physicians and Schools, Pick-Congress Hotel, Chicago.
- Oct. 12 AMA Midwestern Regional Conference on "Voluntary Health Agencies and American Medicine," Stouffer Hotel, Indianapolis.
- Oct. 23 Second Annual Sex Education Workshop, MSMS Headquarters, East Lansing, all day.
- Oct. 29 Fourth Diabetes Day, Genesee County Medical Society, Flint.
- Nov. 5 MSMS Council, MSMS Headquarters, East Lansing, 9:30 a.m.
- Nov. 20 Lansing Dietetic Association, MSMS Headquarters, East Lansing, 7 p.m.
- Nov. 30-Dec. 3 American Medical Association Clinical Convention, Denver.

Extract of MSMS Council Minutes, April 30

Guests at this meeting included D. N. Sweeny, Jr., M.D., chairman of the Michigan Delegation to the AMA; Edwin J. Holman, Department of Medical Ethics, American Medical Association; James Imboden, Field Representative, American Medical Association, and Louis F. Hayes, M.D., vice president of Michigan Medical Service.

The Council received reports from MSMS representatives to the following meetings:

a) First National Conference on Abortion Laws, b) Fifth Annual Conference of State Mental Health Representatives, c) Annual Meeting of the Student American Medical Association.

Nominations for appointment to the Michigan Hospital Service Medical Advisory Committee were submitted after polling The Council by mail. Three nominations were presented: John B. Bryan, M.D., Royal Oak; Hugh M. Fuller, M.D., Detroit; D. Bonta Hiscoe, M.D., Lansing; and S. Newton Kelso, Jr., M.D., Monroe. An additional nominee was added because of the resignation of one of the members of the Advisory Committee.

The Council approved nomination to the Michigan Department of Public Health subcommittee working on intensive care-coronary care units, submitting the name of Gerald N. Breneman, M.D., of Detroit.

Chairman Taylor reported on his attendance at the Third AMA Socio-Economic Conference, in Chicago, and at the MSMS Health Planning Conference in Kalamazoo in April.

Chairman Taylor also announced to The Council that he had accepted with much regret Mr. Richard Campau's resignation. Mr. Campau was a long-time MSMS employee who served as Research Director and staff assistant to many committees of the House of Delegates, The Council, and MSMS.



Mr. Campau's loss will be deeply felt and The Council expressed its regret that it was necessary for him to leave. Mr. Campau will become the Executive Director of the Michigan Nursing Home Association.

THE MICHIGAN MEDICAL SERVICE report contained a discussion of the objections of The Council to the Blue Shield letters to patients and physicians where fees were in question. Also in the written report, discussion dealt with the over-screen letters, per-case participation, full participation, Regional Medical Advisory Committees, government inquiry re Medicaid payments, Social Security Administration fee freeze, and other miscellaneous matters.

In discussion of a possible freeze by the Social Security Administration of Medicare fees, it was noted that the AMA definition of usual and customary charges is somewhat different from that adopted by MSMS.

President Lightbody and Chairman Taylor both reported on their attendance at Blue Shield Board meetings and this was discussed in detail. In addition, Doctor Lightbody reported on his attendance at the MAP Congress, dedication of the Towsley Center in Ann Arbor, Beaumont Lecture in Detroit on April 7, and plans for the

MSMS Annual Session. He also attended other state medical society meetings, gave an address to the Michigan Nursing Home Association and attended the Michigan Conference on Maternal and Perinatal Welfare sponsored by MSMS.

SECRETARY JOHNSON REPORTED that MSMS was continuing its cooperation with component medical societies in the new Crash Injury Research Project conducted by the Cornell Automotive Crash Injury Research Project. Component medical societies in a new study area were outlined.

After consultation with representatives of Michigan State University, The Council supported in principle the need for financial grants-in-aid to educationally handicapped individuals desiring to secure medical education and agreed to actively solicit from MDs and other interested persons and groups funds which, when collected, could be disbursed as grants-in-aid to interested medical schools requesting such aid.

The Council's Publication Committee had a conference with Mr. Allen of Allen Photographic Corporation in an attempt to clear up some of the misunderstandings and dissatisfactions which have come to the attention of MSMS from members of component societies across the state. Mr. Allen reported that two sales representatives had been dismissed and that every effort is made to correct any misunderstandings and to improve the total operation.

The Council took action on the following committee minutes: Nursing, Podiatry, Governmental Medical Care Programs, Public Health, Legal Affairs, Rehabilitation, Hospital Privileges, Liaison with State Bar of Michigan, Quackery, Child Welfare, Mental Health, Maternal Health, Planning for the 1969 Annual Session, Aging, and Cardiac Diseases.

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applicator.
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Anterior Mediastinotomy As A Means Of Diagnosing Bronchogenic Carcinoma

BY S. AMJAD HUSSAIN, M.B., B.S. DAVID GLOW, M.D.
J. C. ROSENBERG, M.D.
ALL OF TOLEDO, OHIO

When a roentgenogram of the chest demonstrates an abnormality which could be caused by a bronchogenic carcinoma, the physician is immediately triggered into ordering a series of tests and examinations to establish a specific diagnosis.

ADDITIONAL ROENTGENOGRAPHIC VIEWS of the lesion, laminograms, skin tests, sputum cytology, fluoroscopy, angiography of various sorts (pulmonary arteriography, superior vena cavogram, azygogram, aortogram) bacteriologic studies, bronchoscopy, bronchography, scalene fat pad biopsy and mediastinal exploration are all worthwhile diagnostic procedures. In many instances, the physician's diligent efforts to establish a specific diagnosis are unrewarding. If the patient's pulmonary function is adequate and there is no evidence of neoplastic involvement beyond the limits of operative removal, a thoracotomy can be carried out with the hope that both diagnosis and definitive therapy can be simultaneously performed.

However, only 35-40% of patients with bronchogenic carcinoma are operable. The remaining patients are inoperable because of obvious extension of the lesion beyond surgical cure or because of the patient's inadequate cardiopulmonary function. In the group of inoperable patients, there are those who, despite the aforementioned studies, do not have a specific histologic diagnosis.

IN THESE PATIENTS, needle biopsy of the lesion or anterior mediastinotomy may be of great value. This presentation will relate our initial successes and satisfaction with the latter procedure when all other methods of diagnosis were fruitless.

The need to firmly establish a pathologic diagnosis is more than an academic exercise. A patient's prognosis can be determined only after a tissue diagnosis is established. No patient should be consigned to terminal palliative care with a non-malignant potentially curable lesion. To avoid such pitfalls, a tissue diagnosis must be obtained. Furthermore, as chemotherapeutic agents and

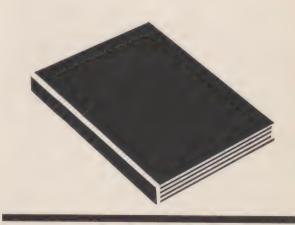
techniques improve and X-ray therapy becomes more exact and proficient, patients with inoperable lesions may be rendered operable; may be significantly palliated; or may even be cured.

Case Material and Results

During the year 1965-66, 32 patients underwent scalene node biopsy as part of their work-up for suspected lung cancer. Only five biopsies were positive (15.6%). Of 27 patients with negative biopsies, 11 underwent thoracotomy. Only one of these 11 was found to have a resectable lesion.

During the same year, 8 patients underwent mediastinoscopy with biopsy of superior mediastinal and paratracheal lymph nodes. All of the 8 patients had negative scalene node biopsies. All of the mediastinoscopies were also negative. When these same 8 patients were subjected to mediastinotomy, the tissue obtained was positive for carcinoma in 6 out of 8 patients (75%) (Table I). Of the two negative biopsies, one was proved to have no cancer on a subsequent thoracotomy for persistent lesion of the right upper lobe. The other patient subsequently died of unrelated causes and chronic inflammatory disease of the lung with amyloidosis was found. No malignancy was present.

The summary of these results and comparison



SCIENTIFIC PAPERS

The authors were with the Department of Surgery at Maumee Valley Hospital in Toledo, Ohio. Doctor Rosenberg is now associate professor of surgery with Wayne State University.

TABLE I

YIELD OF DIAGNOSTIC PROCEDURES IN PULMONARY
LESIONS AT MAUMEE VALLEY HOSPITAL (1965-66)

Diagnostic Procedure	Total Patients	Negative Examinations	Positive Examinations	% Yield
Scalene Node Biopsy	32	27	5	15.6%
Mediastinoscopy	8	8	0	0%
Anterior Mediastinotomy (MVH)	8	2*	6	75 %
Anterior Mediastinotomy (MeNeill & Chamberlain) Ref. (1)	22	3	19	86.4%

NOTE* 1 Proven Negative

1 Died of Unrelated Causes

of our yield of mediastinotomy with those of Mc-Neill and Chamberlain¹ is shown in Table I.

Discussion

The search for a short route to diagnose malignant lesions of the lung and mediastinum has been long and relatively unrewarding. As McNeill and Chamberlain observed, "the literature on anterior mediastinotomy ranges from the classic finding of Virchow's sentinal gland and Rouvier's plotting of lymphatic drainage of the lung to a 1965 report on lung biopsy performed through the bronchoscope."1 Cervical and thoracic approaches to the mediastinum have been employed over a period of time to drain mediastinal abscesses and obtain access to diseased mediastinal structures. Guest and Ellison in 1965 reported successful biopsy of the lymph nodes through anterior thoracic mediastinotomy in two poor risk patients with inoperable carcinoma of the lung.² The need for a productive and facile procedure to diagnose bronchogenic carcinoma becomes more pressing in those patients who have inoperable cancer of the lung and who can not be subjected to palliative treatment without a tissue diagnosis. In our hands, diagnostic procedures other than anterior mediastinotomy have been disappointing.

In 1954, Harken described a technique of visualizing the superior mediastinum through a cervical incision and biopsying the lymph node in that area.3 This technique gives access to middle and posterior parts of the superior mediastinum. It is believed that these lymph nodes are involved in 30-40% of inoperable lung cancer. Carlens^{4, 5} from Stockholm modified Harken's technique of mediastinoscopy and reported a high success rate in obtaining positive diagnoses. Others have reported similar results.6 It was felt that mediastinoscopy may be an answer to the long awaited problem of diagnosing inoperable carcinoma of the lung. However, a significant number of patients require additional diagnostic studies after a negative mediastinoscopic examination.

McNeill and Chamberlain¹ described the technique of anterior mediastinotomy which we have found most rewarding. They reported their experience with this procedure which gives access to

the lymph nodes at the hilum or along the superior vena cava and trachea on the right side and hilar paratracheal and subaortic nodes on the left side. Their largest diagnostic group comprised 22 patients with bronchogenic carcinoma, 19 of whom had a positive tissue diagnosis after anterior mediastinotomy. An additional advantage of McNeill and Chamberlain's approach is that the pleura can be opened and a lung biopsy obtained.

Our disappointing experience with other diagnostic methods led us to try their approach to the diagnosis of inoperable lung cancer and our re-

sults have been gratifying.

Mediastinal tumors independent of the lung or extensions of the carcinoma from the lung into the mediastinum can be exposed and biopsied through an anterior mediastinotomy. The procedure is done under endotracheal general anesthesia which need not be prolonged or deep. No morbidity or mortality occurred in our experience.

Summary

The operative procedures required to establish a diagnosis of bronchogenic carcinoma are reviewed. Anterior mediastinotomy was found to be the simplest and most productive means of obtaining a tissue diagnosis when conventional posterolateral thoracotomy was contraindicated because of advanced disease or poor cardiopulmonary reserve.

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Christmas Disease With Multiple Familial Occurrence

BY FRANK D. JOHNSON, M.D. ROBERT K. RANK, M.D. ROBERT STRALEY, M.T. ALL OF MT. PLEASANT

Christmas disease, or Hemophilia B, is potentially a serious and even lethal disease.

Children with Hemophilia B seldom exhibit a positive family history. Since all cases of hemophilia are congenital, the physician who cares for children is often confronted with a difficult diagnostic and prognostic problem when presented with a patient with a history of recurrent epistaxis.¹

SINCE THE BASIC objectives in the clinical management of bleeding disorders is to replace the missing pro-coagulants in quantities sufficient to insure an effective hemostatic mechanism, knowledge of Hemophilia B can greatly help the physician plan his investigation and ultimate treatment of the patient with chronic nosebleed. It was not until 1952 that it was recognized that Christmas disease (Hemophilia B or Factor IX deficiency) was a distinct entity.²

The purpose of this paper is to present a case of Christmas disease with an interesting familial distribution and a brief discussion of the disease and the diagnostic procedures available.

Family History

The 37-year-old mother of the patient gives a history of bleeding during tooth extraction, but had no abnormal ante or postpartum bleeding. The father, age 40, and two siblings are living and well with no evidence of abnormal bleeding tendencies. The maternal grandfather had a long history of recurrent nosebleeds and died at the age of 42 years of multiple myeloma. Two maternal great uncles have recurrent nosebleeds.

Case History

This 15 year old white male was admitted to the hospital with a history of nasal bleeding for the past three months. The nose bleeds occurred one to three times per day; lasting from one to several minutes. These were associated with left

Doctor Johnson is a private practitioner. Doctor Rank, a pathologist, is Laboratory Director and Mr. Straley is Chief Laboratory Technician at Central Michigan Community Hospital.

frontal headache. The patient stated his nose would feel like it was pulsating and then it would bleed

Physical examination revealed a well developed, large boy with the only positive finding being blood in the anterior nares, B.P. 140/80, weight 2331/2 lbs., height 5 ft. 10 in.

In spite of extensive cautery to Kesselbachs triangle, he continued to have recurrent episodes of epistaxis. Laboratory findings are listed in Table I.

THROMBOPLASTIN GENERATION STUD-IES in the present patient were consistent with Hemophilia B or Christmas disease.

In view of the interesting family history, 13 relatives of the patient were given a "hemorrhagic workup" which included determination of the prothrombin time, thrombofax, fibrinogen, Hicks-Pitney, thromboplastin generation and antihemophilia factor. The results of this "hemorrhagic workup" are seen in Table II.

In summary the maternal family tree exhibits transmission of factor IX deficiency. Table II reveals that the thromboplastin generation test for the patient, his mother and his sister is abnormal. The findings in the patient's great uncle (G.S.) are not valid since he was taking dicumerol at the time of testing.

Discussion

While there are normally six factors known to be involved in the formation of plasma thromboplastin; hemophilia is usually identified with the deficiency of only three of these factors. These three factors are (1) Antihemophilia globulin (AHG) which is deficient in Hemophilia A, (2) Plasma thromboplastin component (PTC) which is deficient in Hemophilia B, and (3) Plasma thromboplastin antecedent (PTA) found deficient in Hemophilia C. The other three factors (Stuart Powers factor, Labile factor, and the Hageman factor) can be detected by the prothrombin time determination. It is of interest that the Hageman factor deficiency produces no hemorrhagic disease.³

SEVERAL RECENT ADVANCES in laboratory studies have made the diagnosis and investigation

TABLE #1
LABORATORY STUDIES

TEST	PRO- TIME	THROMBO- FAX	FIBRIN- OGEN	HICKS- PITNEY	TG- TR	AHF
NORMAL	12-15 sec.	100 sec.	200-500 mg%	less than 16 sec.		
PATIENT	15 sec.	or less 127 sec.	571 mg%	21 sec.	45 sec.	16 sec.

TABLE #II
"HEMORRHAGIC WORKUP" RESULTS IN 13 RELATIVES OF THE PATIENT.

TEST & NORMALS	Pro-time 12-15 sec.	Thrombofax 100 sec. or less	Fib:	rinoge) Mgi			-Pitney . or less		TR PTC	Pt's	AHF	Pt's	(Both)
P-JL 15 12-20-63	C-13" Pt- 15"	127 sec.	571	Mgm	%	21	sec.	45	sec.	16	sec.	16	sec.
M-AL 37 1-2-64	C-12" Pt- 14"	117 sec.	774	Mgm	%	15	sec.	22	sec.	14	sec.	34	sec.
S-KL 9 1-3-64	C-12" Pt- 14"	145 sec.	548	Mgm	%	21	sec.	24	sec.	16	sec.	24	sec.
F-WJL 41 1-8-64	C-13" Pt- 15"	85 sec.	509	Mgm	%	18	sec.	10	sec.	10	sec.	17	sec.
GU-GS 62 1-22-64 taking Dicumerol	C-13" Pt- 20"	85 sec.	725	Mgm	%	16	sec.	93	sec.	15	sec.	176	sec.
B-RL 13 1-23-64	C-13" Pt- 15"	100 sec.	Q	.N.S.		14	sec.	12	sec.	14	sec.	16	sec.
GU-HS 53 2-1-64	C-13" Pt- 15"	88 sec.	656	Mgm	%	15	sec.	11	sec.	12	sec.	16	sec.
GU-LS 66 2-5-64	C-13" Pt- 14"	85 sec.	410	Mgm	%	16	sec.	12	sec.	12	sec.	13	sec.
GU-ES 73 2-12-64	C-12" Pt- 13"	90 sec.	569	Mgm	%	. 17	sec.	14	sec.	14	sec.	14	sec.
MA-JD 44 2-13-64	C-12" Pt- 12"	78 sec.	567	Mgm	%	14	sec.	14	sec.	14	sec.	14	sec.
MC-JD 15 2-14-64	C-13" Pt- 16"	76 sec.	548	Mgm	%	17	sec.	12	sec.	12	sec.	12	sec.
MC-DD 9 2-14-64	C-13" Pt- 16"	85 sec.	626	Mgm	%	22	sec.	13	sec.	13	sec.	12	sec.
MC-CD 19 2-20-64	C-12" Pt- 15"	75 sec.	273	Mgm	%	18	sec.	12	sec.	12	sec.	17.5	sec.

of hemorrhagic disorders much easier. The diagnosis of Hemophilia A, B, and C, is based primarily on two laboratory procedures. The first is the prothrombin time which measures the clotting time of recalcified plasma containing tissue thromboplastin. This test is normal in Hemophilia A. The second test is the thromboplastin generation test (TGTR) which measures the production of thromboplastin. This test is abnormal in Hemophilia B.

Many hospitals in the country now use the "Partial thromboplastin time" test as a screening test to survey patients for bleeding disorders. This test screens for all factors except platelets and calcium in the coagulation mechanism of blood. The test used in our laboratory is commercially available "Thrombofax."

Figure I is a schematic representation of the factors involved in the coagulation mechanism of blood.³

The precise role of factor IX in the clotting mechanism is not known, although it is thought to be important in the first phase of coagulation. There is increasing evidence to suggest that factor IX exists in a precursor form and is possibly changed to active form by factor XI.

It was suggested in 1947 that classical hemo-

philia might not be a single entity but rather a group of hemorrahagic disorders. It is now well recognized that the term "Hemophilia" does not define a single entity, but a group of hemorrhagic disorders. It was not until 1952-1953 that Hemophilia B and Hemophilia C were distinguished from Classical Hemophilia by Aggeler and associates.

CHILDREN WITH MILD Hemophilia B or PTC deficiency are a problem to the physician since only a small percentage have a positive family history. Moreover, certain surgical procedures that are extremely common in childhood, are those most likely to provoke serious unexpected hemorrhage!

Although sensitive and reasonably rapid screening tests are now available, it still does not seem feasible to perform these routinely on all children recommended for dental extraction, but it does seem logical that all patients for tonsillectomies and adenoidectomies and other surgical procedures should have these tests. At present a careful personal and family history would seem to be the best practical way to determine bleeding tendencies.

In mild factor IX deficiency, coagulation time and prothrombin consumption time may be nor-

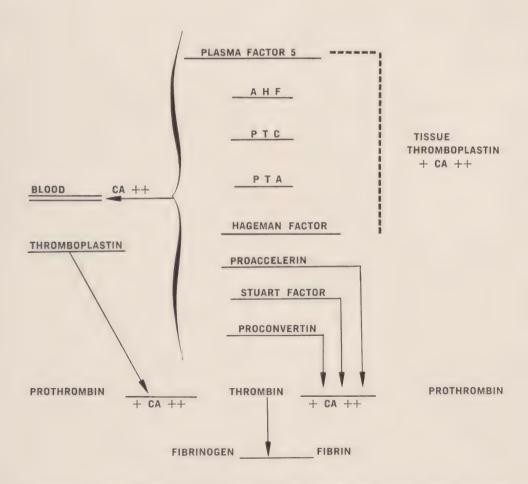


FIGURE I Schematic representation of the factors involved in the coagulation mechanism of blood

mal or nearly so, and the deficit can be detected only by the thromboplastin generation test.

Hemophilia B constitutes 21% of all hemophilia. Over one-half of the carriers with a demonstrable defect by test have been reported as having had at least one significant hemorrhagic episode. The PTG deficiency is transmitted as a sex-linked recessive trait; therefore it usually occurs only in the male.⁵ The trait may not always be completely recessive in the heterozygous female as has been shown in a number of studies. These females with significantly reduced factor IX levels, however, were able to withstand considerable trauma without dangerous loss of blood.

In 1958 Biggs and McFarlane reported 20 cases of hemophilia with 13 having Hemophilia B.6 All these cases had normal clotting times. Kurtides reported a series of cases between 1954 and 1962 in which he found 76% classical Hemophilia A, 19% Hemophilia B and 5% Hemophilia C. This study covered eight years and 914 cases of hemophilia.4

TREATMENT OF PATIENTS with Hemophilia B lies first with the recognition of the defect. Unnecessary surgical procedures have to be avoided; e.g., T & A and teeth extractions. If surgery is necessary the patient can be treated with transfusions of whole blood and/or plasma. The relative stability of factor IX as compared to factor VIII and the presence of factor IX in plasma offers a theoretical advantage over classical Hemophilia.

Aggeler reported that factor IX activity in fresh serum is three to six times that in plasmin. Many of the advances in the basic research related to factors VIII and IX have been directly applicable to clinical management of the patient.

The present patient is an example of Hemophilia B with a heterozygous mother.

Summary

The case of a fifteen year old boy with proven Hemophilia B is presented. A study of the patient's family revealed that the great-uncle of the patient had Hemophilia B and that the mother and sister were carriers of the disease. A discussion of the diagnosis of this disease, the problems posed in a patient with a bleeding tendency and a method of handling this type of situation is presented.

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Since the legislature has passed a law requiring routine screening for Phenylketonuria it will be interesting for those concerned with the care of newborns to see the results such screening has brought to date. It is also interesting to note the ratio of false positives to true positives (12:1). This might be of assistance to those dealing with this problem. —John W. Moses, M.D., Scientific Editor.

Phenylketonuria in Newborns

BY K. STANLEY READ, Ph.D., LANSING RICHARD J. ALLEN, M.D., ANN ARBOR THERESA B. HADDY, M.D., LANSING

The inherited metabolic disorder phenylketonuria (PKU), first described by Fölling in 1934,1 is caused by deficiency of the liver enzyme phenylalanine hydroxylase. Its manifestations consist of a characteristic pattern of high blood phenylalanine, normal blood tyrosine, and excretion of phenylpyruvic acid in the urine.

Most patients with classical PKU, if untreated, develop moderate to severe mental deficiency.² The disease is treatable, however, and infants who are started on a low phenylalanine diet within the first few months of life usually respond by developing normally. Their intelligence quotients, although below those of their non-phenylketonuric siblings, have been reported close to or within normal limits.^{3,4}

Surveys of high-yield populations, such as patients in state homes and training schools, children being evaluated for mental retardation, and relatives of known phenylketonurics, have been carried out in Michigan.^{5, 6} Many children who are too old to benefit from treatment have been identified in this way.

EARLY IDENTIFICATION OF infants with the disease, followed by initiation of treatment and prevention of mental retardation, would appear to be much more rewarding. For this reason, newborn infants are now being surveyed while still in the hospitals of their birth.

The value of screening newborns for PKU is now so generally well accepted throughout the

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United States that the majority of states, including Michigan, require routine testing of newborn infants. The purpose of this paper is to report the results of the Department of Public Health newborn screening program from its beginning in 1962 through 1968.

HISTORY OF GUTHRIE TESTING IN MICHIGAN

The Children's Bureau of the United States Department of Health, Education, and Welfare sponsored a trial of the Guthrie method for detection of PKU in newborns from fall, 1962, through December 31, 1963, in which the State of Michigan took part.⁷ The program was jointly administered by the Bureau of Laboratories and the Bureau of Maternal and Child Health of the Department of Public Health.

During this period of time, 16,298 blood tests were performed on Michigan newborns and two cases of PKU were discovered. From the total number of 404,568 tests done by 32 states, a total of 37 cases of PKU was identified.⁷

THE GUTHRIE TEST was also performed on urine specimens at first but urine testing was later discontinued because the blood test was more convenient and efficient. It was concluded that the Guthrie test for blood phenylalanine was effective for detecting elevated blood phenylalanine levels and, therefore, useful for screening newborn infants for PKU.

Based upon the Children's Bureau's successful experience, the Department of Public Health expanded its PKU screening program. All hospitals in the state that had maternity facilities were invited to send blood specimens to the state laboratory from all of their newborn infants. Hospitals that agreed were furnished supplies. Although only 10 hospitals were included in the original trial, additional hospitals later voluntarily joined the program. The number of tests performed gradually increased as physicians in Michigan became con-

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Figures obtained from Center for Health Statistics, Michigan Department of Public Health. Bureau of Laboratories, Michigan Department of Public Health.

by

Guthrie

Laboratories approved of Public Health.

Bureau of Laboratories, Michigan Department

vinced of the usefulness of the screening program.

Legislation was introduced. A bill, Act No. 119 of the Public Acts of 1965, was passed, signed, and made law on August 1, 1965. The law stipulated that "the physician in charge at the birth of any infant" administer or cause to be administered, a PKU test approved by the Director of the State Department of Public Health. The law was later amended by Act No. 228 of the Public Acts of 1967, dated July 10, 1967, to require that "the physician in charge of the care of any newborn infant" be responsible for administration of the PKU test. Rules and regulations were promulgated to implement the law.

All hospitals in Michigan were apprised of the law and were invited to participate in the screening program being carried out by the Department of Public Health. Hospitals sending blood specimens to the state laboratory for processing will be called "participating hospitals" hereafter in this paper.

Not all hospitals wished to use the services of the state laboratory. Hospitals preferring to carry out Guthrie tests in their own laboratories were approved and registered by the Bureau of Laboratories after being proficiency tested. These hospitals will be referred to as "non-participating hospitals" and their laboratories as "registered laboratories" from now on.

Most hospitals in the state by spring, 1966, and all hospitals by summer, 1967, routinely tested their newborn infants, either through participation in the Bureau of Laboratories' program or by doing Guthrie testing in their own laboratories.

From the beginning of the program, all suspects detected either by the state laboratory or by the registered hospital laboratories have been referred to the University of Michigan Medical Center, where diagnostic evaluation has been carried out (by R.J.A.).

MATERIALS AND METHODS

Testing of newborns for PKU continues as an ongoing program in Michigan. The Bureau of Laboratories performs the Guthrie test, as described by Guthrie and Susi,⁸ for participating hospitals. Non-participating hospitals do testing in their own registered hospital laboratories, which are quality controlled on a regular basis by the Bureau of Laboratories.

In participating hospitals, heel-stick blood samples are collected by hospital nursery personnel on a special absorbent filter paper furnished by the Department of Public Health for this purpose. Sterile lancets and self-addressed return mailing envelopes are also furnished. Specimens are collected and mailed in at frequent intervals. Testing is done by the state laboratory upon the day of arrival and duplicate reports are issued to the hos-

pitals, one copy each for the patient's record and for the physician.

The Rules and Regulations require that specimens from normal birth weight infants who are fed cow's milk formula should be collected at least twenty-four hours after the first protein feeding and within the first three days of life. Breastfed babies are to be tested during the fourth to the tenth day of life and specimens should be taken from low birth weight infants weighing less than four pounds, eight ounces, between the seventh and fourteenth days of life.

BLOOD SAMPLES TAKEN earlier than the recommended times are considered unsatisfactory. Specimens that are inadequate in quantity are also considered unsatisfactory. We request another specimen for either reason.

Recent evidence suggests that babies tested in the first day of life without prior protein feeding may have elevated blood phenylalanine levels if they have classical as contrasted to atypical PKU. If this initial evidence is substantiated, the Rules and Regulations may eventually be modified accordingly.

A blood phenylalanine level of four or more mg % is considered to be a "presumptive positive" PKU screening test result. Less than four mg % is considered to be negative, or within normal limits. If a specimen is presumptive positive, the physician caring for the infant is notified, with the request that a follow-up specimen from the infant be collected and sent to the state laboratory. If the initial blood phenylalanine level is high and remains high, we feel that immediate further testing under controlled conditions is necessary.

IF THE PATIENT has PKU, he is considered to have a "confirmed positive" PKU screening test result. Low birth weight infants, especially those receiving high protein formula feeding, frequently have transient mild blood phenylalanine elevations. Such infants are followed by serial tests. The blood phenylalanine usually subsides spontaneously and no further follow-up is necessary. If an elevation persists, however, or if an initial low level increases, the physician is encouraged to seek consultation. We consider it extremely important to follow every infant with a presumptive positive PKU screening test, either until the blood phenylalanine level falls to normal or until a diagnosis has been made.

It is strongly recommended that treatment not be started until after the diagnosis of PKU is made. Confirmatory studies may be carried out at the Clinical Research Unit of the University of Michigan Medical Center, which is sponsored in part by the Children's Bureau and by the National Institutes of Health. When indicated, newborn infants suspected of having PKU may be hospitalized there without charge for definitive laboratory study and consultation.

RESULTS

Since the beginning of Michigan's screening program, 31 confirmed cases of PKU have been identified in newborn infants.

Included in Table 1 are the total numbers of live births, newborns tested (by participating hospitals using the state laboratory and by non-participating hospitals using their own registered laboratories), presumptive positive tests, and confirmed positive tests for PKU in Michigan during the years 1962 through 1968. It is apparent that the number of tests increased each year and rose sharply after the mandatory testing law was passed in 1965.

The total number of presumptive positive tests during the entire seven year screening program was 392. Of this number, 31 eventually proved to have PKU. Eighteen of the 31 infants with PKU were identified by the state laboratory, 12 by registered hospital laboratories, and one by the Clinical Research Unit, University of Michigan Medical Center.

Table 2 lists the patients chronologically by date of birth and indicates sex, birth weight, time when initial blood specimen was taken (age in days), initial blood phenylalanine level (mg %), county of birth, place where test was performed (state laboratory or registered hospital laboratory), and type of PKU (classical or atypical). As would be expected in a non-sex-linked genetic disorder, the number of males and females was approximately equal, with 14 males and 17 females. The infants ranged in weight from five pounds, eight ounces, to nine pounds, seven ounces. It is of interest but only coincidental that none of the cases of PKU occurred in infants weighing less than five pounds, eight ounces, or 2,500 grams. The disease is known to occur, although rarely, in low birth weight in-

ALL SPECIMENS TESTED by the state laboratory were taken from infants between two and five days of age. Two specimens received from registered laboratories were collected before the optimum time; the first specimen from patient number 3 was taken on the second day of life and the one from patient number 11 on the first day of life. In addition, the first blood sample from patient number 24, for quantitative fluorometric assay, was taken at the University of Michigan Medical Center on the second day of life. An increasing number of infants will undoubtedly be identified through sibling follow-up. Patient number 24 is included in this paper because the older sibling, patient number 5, was first identified by Guthrie test through the state PKU screening program. Initial blood phenylalanine levels varied from 2-4 to over 20 mg %.

Of the 31 patients, 22 had the classical form of PKU. Most of the initial blood phenylalanine levels for these infants were between 12 and 20 mg %. Exceptions were patients number 3, 11, and 24. Their specimens had been collected early but were nevertheless presumptive positive at >5, 6,

TABLE 2

NEWBORNS WITH PHENYLKETONURIA (PKU) IDENTIFIED THROUGH THE MICHIGAN GUTHRIE SCREENING PROGRAM

PATIENT NUMBER	BIRTH DATE	SEX	BIRTH	WEIGHT	INITIAL SPECIMEN TAKEN	BLOOD PHENYLALANINE	COUNTY OF BIRTH	WHERE TESTED	TYPE OF PKU
			lbs.	oz.	age in days	mg %			
11	3-28-63	F	7	14	2	>20	Kent	State Lab.	Classical
2		F	6	11	3	12-20			
	6-15-63						Wayne	State Lab.	Classica
32	9- 1-64	F	7	6	1	>5	Wayne	Mt. Carmel Mercy Hospital, Detroit	Classica
4	1-27-65	F	5	141/2	3	12	Kent	State Lab.	Classical
5	11- 3-65	F	6	15	5	>20	Osceola	State Lab.	Classical
6	3-27-66	F	8	1	4	12	Saginaw	State Lab.	Classica
7	4- 6-66	M	7	3	7	Positive	Genesee		
,	4- 0-00	IVI	,	J	,	rositive	denesee	St. Joseph Hospital, Flint	Classica
8	9-19-66	F	7	4	5	>20	Wayne	State Lab.	Classica
9	10-15-66	M	8	10	3	12-20	Washtenaw	State Lab.	Classical
					3				
10	12- 5-66	M	9	21/2	3	12	Kent	State Lab.	Classical
113	12- 8-66	F	6	8	0	6	Wayne	Wyandotte Hospital, Wyandotte	Classical
12	1-11-67	M	8	0	4	12	Ingham	Sparrow Hospital,	Atypical
								Lansing	
13	2-18-67	F	6	3	3	4	Wayne	Mt. Carmel Hospital,	Atypical
1.4	4.05.07							Detroit	
14	4-25-67	M	8	2	4	4-6	Genesee	State Lab.	Atypical
15	7- 5-67	F	7	11	8	12	Wayne	Oakwood Hospital, Dearborn	Classical
16	8-22-67	F	7	5	5	4-6	Wayne	State Lab.	Atypical
17	9- 7-67	F	7	4	3	12-20	Wayne	Providence Hospital, Southfield	Classical
18	10- 7-67	M	8	13	3	>20	Kent	State Lab.	Classical
19	10-25-67	M	6	10					
					3	4-6	Wayne	State Lab.	Atypical
20	10-26-67	M	6	93/4	3	12-20	Crawford	State Lab.	Classica
21	10-26-67	F	. 5	8	5	7.6	Wayne	Providence Hospital, Southfield	Atypical
22	10-27-67	M	9	7	3	12	Macomb	St. Joseph Hospital, Mt. Clemens	Atypical
23	11-27-67	M	6	11	3	12-20	Kent	State Lab.	Classical
24	12- 2-67	M	7	21/2	1	8.3	Osceola	University of Michigan Hospital,	Classical
25	12- 6-67	F	6	10	5	>20	Wayne	Ann Arbor Bon Secours Hospital, Grosse Pointe	Classical
26	2-21-68	F	7	8	3	6	Washtenaw		Adventors
27	4-13-68	M	7	6	3	2-4	Wayne	State Lab. Harper Hospital, Detroit	Atypical Classical
28	8-18-68	M	9	2	2	>20	Kont		Oleania
29 ⁵	9- 5-68	M	6	3 7	3 2	Positive	Kent Wayne	State Lab. Detroit Memorial Hospital,	Classical Classical
30	10-24-68	E	7	10	A	10	Warm	Detroit	
		F	7	12	. 4	12	Wayne	State Lab.	Classical
31	11-19-68	F	6	14	5	4-6	Ingham	State Lab.	Atypical

Died at age 10 months. Causes of death listed on death certificate: crib death, pneumonia, and aspiration.

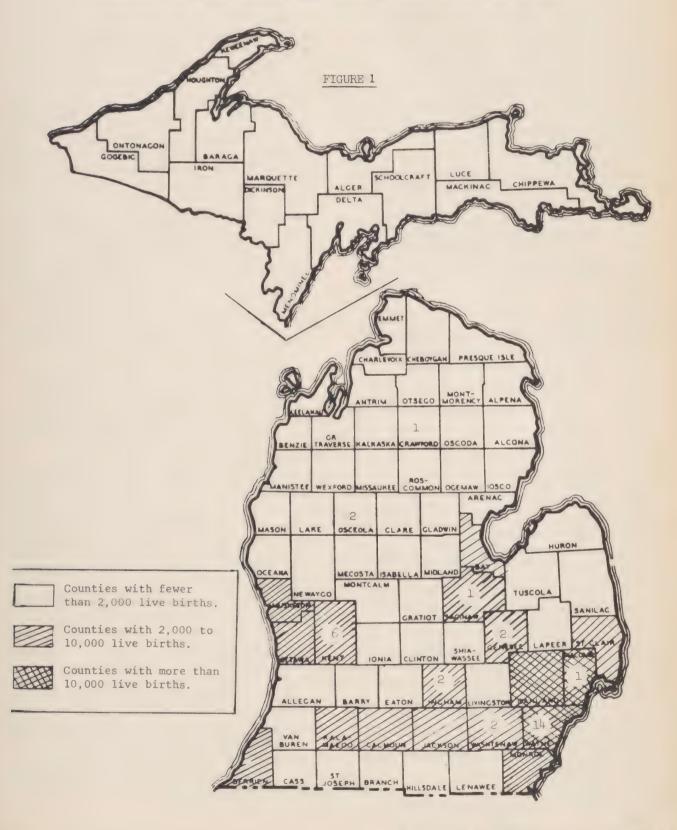
² First blood specimen (Guthrie test) taken on second day of life.

³ First blood specimen (Guthrie test) taken on first day of life.

First blood specimen (quantitative fluorometric assay) taken on second day of life prior to protein feeding. Patient initially suspected because of previously positive sibling (patient number 5).

⁵ Negro infant.

Number of PKU Cases By County Compared To Births



and 8.3 mg %, respectively. Another exception is patient number 27, whose low level of 2-4 mg % is difficult to explain. "Classical" PKU, as used here, means the typical or severe form of PKU.^{9, 10}

Nine infants had atypical PKU. All of them had initial blood phenylalanine levels between 4 and 12 mg %. "Atypical" PKU, as used in this paper, denotes the mild form of PKU^{9, 10} and is equivalent to primary hyperphenylalanemia and to hyperphenylalanemia group 2 of Hsia, Berman, and coworkers.^{11, 12}

All infants with classical PKU were treated with a low phenylalanine diet. It was not necessary to restrict the diets of all of the children with the atypical variant of the disease as rigorously. All of the children's blood phenylalanine levels were carefully monitored.

IT IS KNOWN that PKU occurs in all races. Only one of Michigan's 31 confirmed positive cases in newborns, however, occurred in a Negro infant. The other 30 patients were Caucasian.

The majority of PKU cases, as one would expect, came from areas of high population density and correspondingly high births. Figure 1 shows the number of cases by county compared to births, with births indicated by shading on the map.

COMMENT

Not all infants born in Michigan since the law was passed in 1965 have received the mandatory PKU screening test. According to Table 1, approximately 13,000 newborns were not tested during 1966, probably because not all of the registered laboratories were in full operation. By 1967 and 1968 the numbers tested more closely approached the numbers of births, the figures of each year indicating a disparity of about 4,000.

We compared the numbers of infants Guthrie tested in each hospital with the number of live births in each hospital for 1967 and found that the discrepancy was not localized but spread rather evenly among the hospitals. Reasons for not testing might include the following: infants born outside of hospitals; babies born in hospitals that did not have maternity wards; infants who were ill or who died within the first few days of life; infants who were discharged from the hospital before the recommended minimum testing time; and, rarely, infants whose parents refused to allow the test to be done. In addition, almost 700 babies who were born in federal institutions located in Michigan but outside of state jurisdiction were not tested under the state testing program.

The ratio of confirmed positive PKU cases to live births in Michigan was approximately one in 18,000. This figure is close to the ratio of one in 19,000 found in 2,816,037 tests recently reported from 10 centers in six states.¹²

THE MICHIGAN SCREENING program turned up many "false positive" tests. About one in

every 1,400 newborns had elevated blood phenylalanine levels. The ratio of presumptive positive PKU tests to confirmed positive PKU cases was approximately 12 to one.

Most of the false positives were low-grade blood phenylalanine elevations that became negative upon repeated testing after persisting for variable periods of time. Most transient hyperphenylalanemias occurred in infants of low birth weight, particularly infants receiving high protein feedings. They may be presumed to have had immature enzyme systems. Since the defective enzyme in PKU, phenylalanine hydroxylase, is a hepatic enzyme, the possibility of liver disorders in some of these infants might well be considered. To the best of our knowledge, however, frank hepatic disease was not present in any of the infants who had presumptive positive PKU screening tests. A few false positives also occurred in infants who were dehydrated and infants with neonatal tyrosinemia.

There were, by comparison, very few "false negative" Guthrie tests. Only one new case of PKU was identified among older children born after the mandatory testing law became effective. A mildly retarded child, whose initial screening test by a registered laboratory was said to have been negative, was diagnosed at 17 months of age as having classical PKU. Although there may well be others, this is the only case that has come to our attention so far.

IT MIGHT BE inferred that a good deal of unnecessary follow-up was carried out because of the spontaneous subsidence of most low-level blood phenylalanine elevations and because not all patients with atypical PKU needed treatment with the low phenylalanine diet.

We feel, on the contrary, that the identification of atypical as well as classical cases is extremely important for the following reasons: 1) some of these infants will indeed be in need of therapy, 2) there are genetic implications in identifying index cases, and 3) it may be necessary to treat some mildly affected phenylketonuric females, as well as most females with classical PKU, with a low phenylalanine diet in later years during pregnancy in order to avoid fetal damage. It is therefore essential that every infant with a presumptive positive Guthrie test be followed until either the blood phenylalanine level falls to normal or a definitive diagnosis is made.

The Guthrie test, as used in Michigan, is convenient and comparatively inexpensive for mass screening of newborn infants. It is accurate when done under carefully controlled and standardized conditions. Only one apparent false negative result has come to our attention so far. We believe the test to be satisfactory as it is currently being used in Michigan.

SUMMARY

The results of Michigan's PKU screening program for newborn infants from 1962 through 1968 are reviewed. During that time 31 infants with PKU were identified, 22 having the classical and nine the atypical form of the disorder. There was a relatively large number of false positive tests but only one apparent false negative test as compared to the number of cases of PKU diagnosed. The importance of careful follow-up of all patients with blood phenylalanine elevations, including those with mild elevations, is emphasized. The Guthrie test is an effective screening method for the early detection of PKU in newborns.

ACKNOWLEDGEMENT

We wish to thank W. W. Ferguson, Ph.D., and Kenneth R. Wilcox, Jr., M.D., Bureau of Laboratories; and Thomas R. Kirk, M.D., and Bernard H. Siebers, M.D., Bureau of Maternal and Child Health, Michigan Department of Public Health, for their help and encouragement and for critically reviewing this manuscript.

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Water Pollution in Michigan, Nation No Longer Simple Question Of Possible Health Hazards

By Julia Orwig Lansing

Miss Orwig, a former newspaper woman, is a free-lance Michigan reporter and author.

In Michigan, 26 of the 31 miles of the Detroit River are considered unsafe for water sports and boating. The federal government further warns that Lake Michigan is in serious trouble.

Still some are unmoved.

This is the price of progress, it is said. This is a consumer society — we must compromise in order to enjoy the benefits of a highly industrialized, urban society. So we sit back, we eat things, we wear them, we burn them — we utilize the fruits of our labors, so to speak, and then when we're through we pour the remains into large sewers infiltrating our waters and creating huge open cesspools.

BUT WHAT IS THE pollution problem in Michigan? Just how local has it become?

Michigan has more fresh water per capita than any other state except Alaska. Located in the heart of the Great Lakes, the world's greatest single supply of fresh water, Michigan is indeed in an enviable position as eyed by some of our drier, less fortunate neighbors.

And yet Senator Philip Hart has called water pollution "the most serious threat to Michigan's economic future." And more specifically he has said of Lake Erie, "This huge lake is already well on its way toward becoming a shallow dishpan of soiled water, incapable of supporting any marine life that is not too loathsome to live in sludge."

Yes, Lake Erie is dying an early death spurred on by the pollutants of home, industry, land runoff and navigation. Large areas of public beach on its shores are now posted as unsafe for swimming.

More surprisingly, however, is the fact that Lake Michigan is beginning to show the signs of a long continued abuse. The *Saturday Evening Post* reports that Lake Michigan has been so polluted by Chicago and other industrial cities of Indiana and western Michigan that conservationists estimate it will take over 500 years to recover if things are brought under control now.

STRIKING MORE CLOSE to home, the federal government in a recent report from the U.S.

Department of Interior named 38 Michigan communities as contributing to the severe pollution problem of Lake Michigan.

Many of these communities are mid-Michigan municipalities which indirectly contribute to Lake Michigan's problems through the dumping of only partially treated sewage into the streams and rivers which ultimately drain into the big lake. The government recommends improved municipal treatment facilities to the local governments.

Although the naming of individual communities in the report does not constitute a federal order to take action, if the state government does not institute enforcement, the federal government will no doubt step in.

Also singled out in the report were 68 Michigan industries.

Even beautiful Lake Superior, far from the concentrated industrial, urban centers of our state, has reportedly felt the first signs of pollution. Recently, Richard J. Potter, M.D., Director of the Marquette County Health Department, found it necessary to draft a new sanitary code in an attempt to stop some of the abuse there.

THE GREAT LAKES ARE not the only water sources in Michigan suffering from man's garbage and waste. Just about every major stream in the state is feeling the effects – from the River Rouge and the Detroit to the St. Joseph. Even the beautiful Au Sable, once a fisherman's paradise, has shown signs of man's mishandling. The Michigan Department of Conservation in conjunction with the U.S. Department of Interior has recently seen fit to publish a booklet entitled, "Michigan's Au Sable Today and Tomorrow," by G. E. Hendrickson, warning against the inevitable fate of this famous trout stream if left to man's mismanagement.

Michigan's pollution problems will no doubt intensify as population increases and as urban living expands. Between 1960 and 1965 Michigan's population grew by almost 400,000 and the census years of 1950 and 1960 show an urban population expansion of nearly 3%. Industrial expansion, increased recreational facilities and greater agricultural irrigation will also add to the pollution burden. In 1935 Michigan had 5,544 established industrial concerns within its borders. By 1963 this number had grown to 13,965.

The state and federal governments will have a

Fears Lake Michigan soon to be "shallow dishpan of soiled water."

Pollution threatens lakes, rivers and remote trout streams.

tough time keeping pace with man's increased abuse to his waterways. Governor Romney has estimated that expenditures of \$900 million by 1980 are required to achieve complete water quality control in Michigan. In 1966 approximately \$600,000 including grants in federal aid was spent. Another \$2 million in state grants was used in the construction of local sewage treatment facilities. However, this is still a far-cry from the governor's estimated need.

Federal legislation governing water pollution has been expanded greatly in recent years. The first real action in this area was taken in 1948 with the passage of the Water Pollution Control Act which provided for pollution abatement procedures against both industrial and municipal offenders. This act also provided federal assistance for the construction of local sewage treatment plants and aid to state administration of antipollution programs. Amendments in 1952, 1956, 1961 and 1965 extended this initial act, which proved ineffective for years due to inadequate appropriations from Congress.

The 1961 amendment gave the Secretary of Health, Education and Welfare greater powers of enforcement. In 1965 the program was removed from the Public Health Service and is now completely under the jurisdiction of the Federal Water Pollution Administration within the Department of Interior.

Under the 1965 Water Quality Act, Congress provided that purity standards for interstate waters be established and enforced by the states. If the states fail to act in this capacity the federal government may step in and set up its own standards. Federal enforcement proceedings may be initiated against offenders if and when pollution effects involve more than one state. Such proceedings may take the form of a conference, a hearing, and finally if all else fails, court actions may be started.

In 1966 Congress passed the Clean Water Restoration Act which provides appropriations of \$3.55 billion to be spent during the period from 1967 to 1971 for sewage treatment plant construction. Federal grants for research on industrial water pollution and on advanced waste treatment; assistance for river basin planning organizations, state and inter-state pollution control agencies; and extended powers for use in cases involving international pollution were also provided for.

MICHIGAN'S LEGISLATIVE history in the area of water pollution is built around Public Act 245 of 1929 which created the Stream Control Commission. Later in 1949 this Commission was replaced with the present Water Resources Commission. In 1963 and again in 1965 this act was amended to provide state powers of enforcement. The 1965 amendment further provided penalties including criminal charges against violators.

The 1966 legislature passed Public Act 222 which provides tax exemptions on personal property for industries installing new equipment designed primarily for water treatment. Personal property which becomes a structural part of the real estate of the industrial facilities is further exempt from sales and use taxes.

Today's State Water Resources Commission consists of seven members representing the major interest groups of the state government and citizenry. Heads of the Departments of Health, Agriculture, Conservation and of the Highway Department serve as ex-officio members along with three appointed citizen members.

Within the framework of federal legislation several interstate conferences have been called in recent years involving Michigan and other states which contribute to the pollution of the Great Lakes. At a recent conference held concerning the Michigan waters of Lake Erie, effluent standards for both industry and municipalities were established for the Detroit area.

Early in 1967 the Great Lakes Basin Committee was established under the Federal Resources Planning Act of 1966. This organization was created to coordinate the water resource programs of the entire Great Lakes region.

ASIDE FROM GOVERNMENTAL action in Michigan, much is also being done by independent groups seeking to promote pollution control in our state. Industry, for example, has recently become increasingly active. Manufacturers have seen the writing on the wall as federal intervention has been threatened or they are actually feeling more responsibility for the conditions. Individual industrial concerns, as well as their protector and promotional representative, the Michigan State Chamber of Commerce, have become active in the fight against water pollution.

As in the case of air pollution, the State Chamber worked diligently to promote the passage of Public Act 222 which provides for tax exemptions for industry which installs pollution control devices. The Chamber has also been active in working with state legislators in establishing water quality standards for the state.

Some of the larger industrial concerns of Michigan have independently developed their own research laboratories in hopes of finding more efficient and adequate water purification facilities. Dow Chemical Company of Midland, for example, has been developing new chemicals which Dow hopes may ultimately replace mechanical means of cleaning up sewage-contaminated waters.

AN EXTENSIVE ATTACK on water pollution is underway at the University of Michigan with the establishment of a research program. Scien-

Michigan industry, universities step up anti-pollution efforts, research.

tists at the University's Great Lakes Research Division have been gathering data on the Great Lakes since 1945, so this institution was the logical sight for the new program. Drawing from just about every possible resource on campus, scientists from several departments are conducting research on every phase of the water pollution problem.

A recent research report from the University explains a new phase of the overall project. Professor John J. Gannon has constructed an outdoor experimental channel which draws its water from the Huron River and is conducting research into the health aspects of water quality. This artificial river may ultimately help in solving the problem of organic pollution which promotes the growth of algae decreasing the amount of dissolved oxygen in our lakes and streams. This process has been blamed for the tremendous fish kills in the Great Lakes in recent years.

At Michigan State University research into the causes and possible cures of water pollution is also being conducted. C. R. Humphrys of the Department of Resource Development, for example, has written extensive material on the multiple uses of our water resources. As one of the chief proponents of the idea that health and quality standards alone will not protect all of our water interests, Professor Humphrys has been instrumental in promoting recreational water needs in Michigan.

The federal government's decision to move the Pollution Control Administration to the Department of Interior reflects the fact that water management involves many varied and complex considerations. Recreational, industrial, agricultural interests, as well as municipal authority, must all be considered in policy formation.

AN UNDERSTANDING OF the various types of pollutants which are being poured into Michigan's streams and lakes will provide some insight into the complexities of the problem. As classified by the Senate Committee on Public Works, pollutants fall into the following classifications:

- (1) Organic wastes from domestic sewage and industrial discharges of plant and animal origin which remove oxygen from the water through decomposition.
- (2) Infectious agents contributed by domestic sewage and some kinds of industrial wastes which may transmit disease.
- (3) Plant nutrients which promote nuisance growths of aquatic plant life such as algae and water weeds.
- (4) Synthetic-organic chemicals such as pesticides and detergents resulting from the constantly changing chemical technology which may be toxic to aquatic life and to humans.
- (5) Inorganic chemicals and mineral substances from mining, manufacturing processes, petroleum

plants, and agricultural industry which interfere with natural stream purification, destroy fish and other aquatic life, cause excessive hardness in water supplies, produce corrosive damage, and in general add to costs of water treatment.

- (6) Sediments which fill stream channels, reservoirs, harbors, erode hydroelectric power and pumping equipment, affect fish and shellfish by blanketing fish nests, spawns, and food supplies and increase costs of water treatment.
- (7) Radioactive pollution from mining and processing of radioactive ores, from use of refined radioactive material, and from fallout following nuclear testing.
- (8) Excessive temperatures from use of water for cooling purposes, for example, and from impoundment of water in reservoirs. This may result in harmful effects on fish and aquatic life and may reduce the capacity of the receiving water to assimilate wastes.

Officials are seldom faced with just one pollutant. In a stream or lake wastes become mixed and often it is difficult to separate the resultant mixture even for purposes of analysis.

Then too there is the problem of types of water. In considering today's pollution people usually think primarily of surface waters. However, there is also the possibility of ground water contamination. Although the instance of this is decreasing with the instrumentation of our new pollution laws, it is still a consideration in suburban and rural areas.

Instances of infectious diseases contracted from contaminated water are on the decline due to new improved purification standards. However, there is always the possibility of a slip-up in the purification process.

Just what the long-range effects of pesticides will be on humans who swim in infected waters or eat fish which have collected these residues in their bodies is unknown. However, it is something to be considered by researchers and physicians alike.

There are many problems involved in water pollution control. Much has and is being done right here in Michigan to correct the situation brought about by years of abuse to our waterways. However, there is much more which can and must be done.

THE MEDICAL PROFESSION as a group and as individual citizens should play an active role in seeing that water pollution is cleaned up in Michigan. It is necessary that physicians make themselves aware of the possible types of pollution of all water sources within their community.

Water pollution is a changing, many faceted problem. It is no longer simply a question of immediate health hazards.



The burdened heart...

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy). Contraindicated: Known hypersen-

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Scientific Articles Printed to Date

Each month *Michigan Medicine* prints selected outstanding scientific articles. To date, the following papers (with month, page number and author following) have been published:

JANUARY

- Page 31, "Lower Lung Field Tuberculosis," by Ma. Zenaida Fernandez, M.D., Zamboanga City, The Philippines, and Edward G. Nedwicki, M.D., Allen Park.
- Page 36, "Use of Cholesterol Kits," by Kenneth R. Wilcox, M.D., (Reprint from New England Journal of Medicine, Vol. 279, No. 18).
- Page 37, "Mammography and Xeroradiography," by John N. Wolfe, M.D., Detroit.
- Page 39, "Early Management of Facial Nerve Trauma," by Roger Boles, M.D., Ann Arbor.
- Page 45, "Treatment of Hypercalcemia," by Joseph J. Weiss, M.D., and Jose Yanez, M.D., both of Eloise.
- Page 49, "More Drugs Mean More Problems in Managing Diabetes Mellitus," by John B. Bryan, M.D., F.A.C.P., Royal Oak.

FEBRUARY

- Page 119, "The Future of Private Practice: Salvation at the Grassroots;" by Lewis A. Miller, Stamford, Conn.
- Page 131, "Mouse Toxicity of Triple Vaccine (DTP) Mixed with Poliomyelitis Vaccine," R. Y. Gottshall, G. R. Anderson, E. A. Nelson and K. R. Wilcox, M.D., all of Lansing.
- Page 135, "Massive Intra-articular Injection of Methylprednisolone without Harmful Side Effect," by J. C. Breneman, M.D., Galesburg.

MARCH

- Page 209, "Myocardial Infarction During Hyperthyroidism," by Robert C. Douglass, M.D., Southfield; Myer Teitelbaum, M.D., Detroit, and Gerald J. Aben, M.D., Southfield.
- Page 213, "Trichophyton Violaceum," by JamesD. Stroud, M.D.; Jules Altman, M.D., and Coleman Mopper, M.D., all of Detroit.
- Page 215, "Psychiatric Referral of a Pediatric Patient," by Joan R. Chodorkoff, Ph.D., and Bernard Chodorkoff, M.D., Ph.D., both of Detroit.
- Page 217, "Development of a Program of Laryngoscopy, Therapeutic Bronchoscopy and Endobronchial Blocking Techniques: A Progress

- Report," by Martin L. Norton, M.D., F.A.C.C.P., Detroit.
- Page 220, "Accidental Poisoning, Where Do We Go From Here?" by George M. Lowrey, M.D.
- Page 221, "Diabetes and Pregnancy Preliminary Report," by Nancy T. Caputo, M.D., and Agna N. Pineda, M.D., both of Detroit.
- Page 223, "The Electrophoresis of Lipoproteins," by John G. Batsakis, M.D., and Martha M. Thiessen, M.S. (ASCP), both of Ann Arbor.

APRIL

- Page 341, "Suprapubic Cystostomy In Gynecologic Surgery," by Morton R. Lazar, M.D., F.A.C.S., F.A.C.O.G., and Eugene A. Snider, M.D., both of Detroit.
- Page 345, "Rhabdomyosarcoma: Report of 20 Cases," by Lawrence S. Bizer, M.D., Detroit.
- Page 349, "Psychiatric Referrals In A General Hospital," by Wiecher H. Van Houten, M.D., Ann Arbor.
- Page 353, "The Sinai Hospital Low Vision Clinic," by Morris J. Mintz, M.D., Ernest M. Gaynes, O.D., and Arnold H. Gordon, O.D., all of Detroit.
- Page 357, "The Physician and Differential Diagnosis of Communicative Disorders in Children," by Gerald S. Light, M.D., and William Wolski, Ph.D., both of Flint.

MAY

The issue featured special Michigan Week articles by leaders in health care in Michigan.

JUNE

- Page 571, "An Emergency Air-Ground System for Newborn Infants with Emergency Distress Syndrome," by L. J. Arp, Ph.D., R. E. Dillon, Mary Tom Long, M.D., and C. L. Boatwright, M.D., all of Blacksburg, Va.
- Page 575, "Experience with Thyroid Malignancy in a Private Referral Laboratory," by Joel I. Hamburger, M.D., Southfield.
- Page 581, "A Diabetic Has A Stroke," by Richard D. Hohl, M.D., Detroit.
- Page 581, "Night Dose May Control Brittle Diabetic," by Jack A. Litwin, M.D., Detroit.



MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FOUR-WEEK PERIOD ENDING MAY 30, 1969

	1969 This 4-Week Period	1968 Same 4-Week Period	1969 Total To Above Date	1968 Total Same Date	Total Cases for 1968
Rubella	797	255	2,628	1,072	1,953
Measles	33	40	141	197	352
Whooping Cough	4	18	54	204	429
Diphtheria	_	_			
Mumps	619	2,061	3,103	11,451	14,655
Scarlet Fever &					
Strep Sore Throat	789	878	5,298	5,982	10,101
Tetanus		_	1	1	5
Poliomyelitis (paralytic)	-	_	_		3
Hepatitis	231	163	1,326	772	2,356
Salmonellosis					
(Other than S. typhi)	34	58	178	263	614
Typhoid Fever (S. typhi)	_	_	3		1
Shigellosis	23	18	131	89	346
Aseptic Meningitis	1	4	35	24	265
Encephalitis	8	13	40	44	114
Meningococcic Meningiti		9	71	46	94
H. Influenzal Meningitis	10	4	24	23	64
Tuberculosis	184	184	999	1,217	2,647
Syphilis	305	511	1,912	2,458	5,351
Gonorrhea	1,331	1,332	7,222	7,065	18,153

Information can be supplied by the local health department on the local incidence of disease.

> R. Gerald Rice, M.D., Director Michigan Department of Public Health

message that concerns one doctor in 20...

As you may appreciate, converting to MVF and coping with the growing pains of a constantly expanding enrollment have created problems for Blue Shield. Yet, considering the difficulties involved, many people would think we're doing pretty well in promptly processing 95 per cent of the 35,000 claims we receive from M.D.'s and D.O.'s every day. But, we're not satisfied. And neither are you, if you're one of the five per cent who has had to wait for payment.

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But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

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Indications: For relief of depression.

Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.

Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.

Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be neces sary in the presence of increased anxiety or agitation, hypomania or manic excitement. However phenothiazines may aggravate the condition Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardio vascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hy pertensive episodes have been observed during surgery in patients on designamine therapy.

Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.

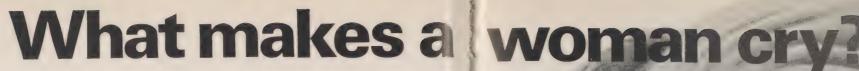
Adverse Reactions: Dry mouth, constipation disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodi lating therapy, particularly during the initial phases. Other adverse reactions include tachy cardia, changes in EEG patterns, tremor, falling mild extrapyramidal activity, neuromuscular in coordination, epileptiform seizures. A confu sional state (with such symptoms as hallucina tions and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaun dice, or liver damage have occurred. If abnormal ities occur in liver function tests, discontinue drug and investigate. Occasional hormonal ef fects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice

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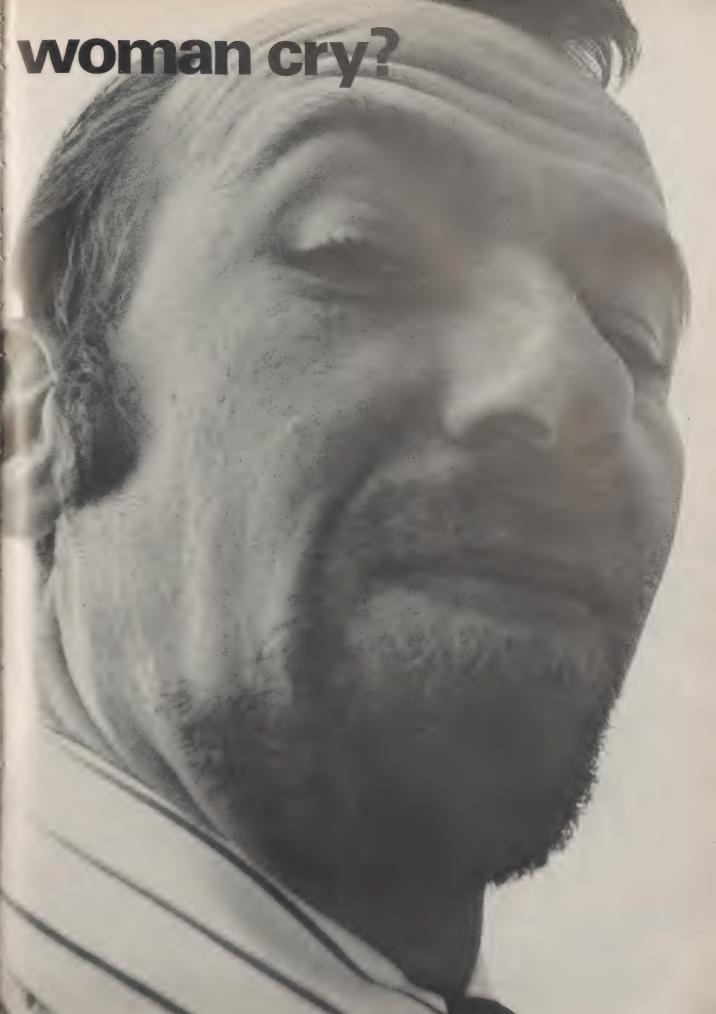
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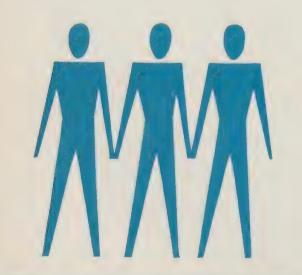
This paper was originally presented at the Third AMA National Congress on the Socio-Economics of Health Care in Chicago March 28-29. Doctor Taylor is chairman of The Council of MSMS and is a specialist in internal medicine.

Medicine's Course for the Future And the Physician As Solo Practitioner

BY ROSS V. TAYLOR, M.D., F.A.C.P. JACKSON

First, I want to specify the fact that "solo practitioner" in this discussion refers only to a physician who is not involved in a group or partnership practice. With modern communications and transportation every physician must recognize that however isolated he may be geographically he is actually and inescapably involved in a complex of health care. The degree of involvement of course may vary but the basic legal and moral responsibilities of practice place all physicians within a framework of interdependence.

The interdependence is constantly increasing not only in professional care relationships but also in socio-economic problems. Unfortunately a majority of physicians continue to avoid any personal involvement in the socio-economic problems, and indeed, despite the efforts to communicate, remain relatively uninformed concerning these problems. Almost every physician will admit a concern about the quality of medical care but too few recognize that the quality of medical care and the economics of medical care are ultimately inseparable.



SOCIO - ECONOMIC

IN CONSIDERING the assignment of medicine's future responsibilities and opportunities in the areas of quality, manpower and financing there are a few facts which will continue to be true in the years to come. First, every individual has a right to medical care. Second, medicine will continue to have the responsibility that the profession renders the best service and highest quality care while continuing to advance medical knowledge. Third, costs will continue to increase. The Durants have said, "History is inflationary." This is also true in medical care.

Medicine will continue to receive criticism for problems beyond immediate control. The tremendous expansion of scientific knowledge in the fields of health care plus the increased expectations of the affluent society have greatly increased the demands for health care.

In addition the external social forces which have been and are causing a foment and transition in all phases of our social structure have and will also affect medicine in the future. Despite the desire of some segments for a completely socialized system of medical care or a universal compulsory national health insurance program, it would seem likely that for some period of time, at least, there will be a mixture of governmental and voluntary health insurance financing health care.

During the interim period of adjustment there must be some further experimentation in determining the best means for more equitable distribution of medical services so that every individual's right to medical care can be truly available. Eight years ago a statement was presented in the 2nd National Congress on Prepaid Health Insurance which points out problems which still exist:

"THE PUBLIC has the responsibility to recognize that increasing health benefits in an enlarging population, and especially during an inflationary period, must cost more and will ultimately require more skilled personnel than is presently available. The limitations of personnel will probably be the final factor which will determine the extent of expansion of all medical care regardless of the method of payment." This is still true and will continue to be true.

The medical profession has the responsibility to maintain quality of care and its proper utilization. Quality and economics must go hand in hand since excessive use of services is not quality care and inferior care which may cost less is desired by no one.

Assessment of quality begins with the selection of medical students since there are not enough places in entering classes of medical colleges for all qualified applicants. Expansion of entering classes in medical colleges is under way but does not seem likely to be able to fill the expanding desires for services in the foreseeable future. It is possible that society's desire for medical service may force a shorter period of study in medical curricula. Medical colleges may also have to emphasize the teaching of more students and the apportionment of less time to academic research.

It would seem advisable for the maintenance of post-graduate education and quality of care that medical colleges develop affiliations with surrounding community hospitals and incorporate some selected well trained community physicians into their post-graduate training programs with teaching appointments and rotate these community physicians back to the academic center for an annual one or two months combined teaching and educational refresher experience.

SEVERAL MEDICAL colleges have recently initiated programs which are essentially comprehensive service prepaid group practice plans. These experiments may present educational opportunities for academic centers to serve as the source of primary care for a portion of the population and perhaps attract more graduates to become primary physicians. As an adequate study of this system of medical care in its organization and financing, however, it is doubtful that worthwhile comparative cost information can be obtained since the training centers are so dependent on the continued exploitation of the young physician for their proper functioning. Under these circumstances medicine should take a long look at the length of training requirements after graduation from medical school.

After leaving the academic center the physician, as any real professional, has the personal responsibility to continually further his post-graduate knowledge. Whether this is done through special courses, educational meetings, reading, audio-tapes, etc., is up to the individual.

Hospital professional review committees, tissue committees and utilization committees along with other committees are constantly assessing the quality of the care of patients. The quality of office or out-patient care can also be reviewed and will become a general practice in the future. Criteria for such review, however, must be established by physicians and of course will vary depending on the type of practice.

MANPOWER PROBLEMS will continue to plague providers of services for health care. The use of automated techniques will increase as must the use of the new medical assistants. We now must call them "Allied Health Professionals." Individual physicians can train their own personnel to do many things for patients and this will free some time for other patients.

However, there must be greater education of the public and legislators that the threat of malpractice suits is a real influence in some of the spiraling costs as well as a deterrent to increasing use of medical assistants. The public must also be educated in how to seek and use available health care. Simultaneously experiments in supplying aid stations or other units for ancillary medical assistant supervision in rural and isolated areas must be developed. Closed circuit television to such units would make some physician supervision fairly practical. The expansion of practice related to hospitals will increasingly occur.

The development of a standardized history and physical examination form which lends itself to computer analysis would seem inevitable in the near future.

This basic form "Data Base" or "Basic Data," updated periodically, could be machine copied and used in many situations where otherwise additional physician time must be taken. Such a form routinely used in offices could be supplied in every hospital admission as well as used for obtaining driver's licenses, life insurance, statements of health for employment, employment physicals, referral information and in many other similar situations. This data basic form could also be easily transmitted by telephone devices and might save the expense of some of the proposed computer storage centers.

One manpower problem much in the news recently concerns the family or personal physician, the general practitioner, or more properly the primary physician. There are decreasing numbers of this vital cog in medical care. It is probably not coincidental that as the health insurance prepay industry expanded, the number of general practitioners declined.

None of the current coding of services have as yet been able to describe and identify the services of non-surgical care in a way that establishes fair reimbursement. Attempts to establish adequate descriptions for non-surgical care have been made in the RVS of California and also of Michigan but still there is no good coding available and this includes the revised C.P.T. of the A.M.A. Probably the only way to reimburse on a fee for service basis where an easily identified procedure is not done, would be an hourly basis as is used by psychiatrists, anesthesiologists, etc.

NO MATTER what terminology or specialty designation may be used to classify the primary physician or family physician he will remain in short supply unless adequate methods of reimbursment are developed. There will be many physicians for readily identifiable procedures but decreasing numbers for personal physician's services. The "usual and customary fee" concept has become

generally used but perpetuates indefinitely existing inequities in physician reimbursement.

The many criticisms of the increasing costs of medical care will continue and the financing of medical care will probably remain a combination of governmental and prepay health insurance with government's share constantly increasing. Even if the total costs were to be assumed by the government it would be desirable that the health insurance industry be retained as fiscal intermediaries since they are demonstrably more efficient in administration.

It is to be hoped that comprehensive health planning and a plateauing of the necessary salary increases to hospital personnel will soon decrease the degree of escalation of costs of hospitalization. Medical advances in patient care, however, will continue and will cause some continuing increase in costs. The controls built in to the "usual and customary" fee schedule for physicians will shortly level physician charges. In the long run, however, the ceilings in the usual and customary charges will probably result in a national fee schedule or else will cause a further mal-distribu-

tion of physicians geographically. Ultimately the "fee for service" principle will disappear.

IN SUMMARY then, as a solo practitioner, I would say that no physician can ever practice entirely alone. The individual physician will remain an indispensable part of any health care system. Economics will group physicians together for the sharing of expensive equipment even though some may remain independent in practice without group or partnership affiliation. Some members of any affluent society will always desire a personal physician.

Furthermore, while every individual has a right to medical care, and while there are many more benefits available to patients than ever before, and no matter what the method of financing, there will remain problems in the distribution of and accessibility of health care because of the limitations of personnel. And finally, the profession itself has the primary responsibility for maintenance of the quality of care but must be constantly mindful of the fact that the quality of care and economics of health care are inseparable.

The following talk also was given at the Third National Congress on Socio-Economics of Health Care held during the spring in Chicago.

Cost and Fees for Physicians' Services

BY W. FRED MANGAN PROFESSIONAL MANAGEMENT BLACK AND SCRAGGS ASSOCIATES BATTLE CREEK, MICH.

Significant and rapid changes have been occurring in the business side of private practice as represented by clients of the PM Group. Perhaps the period 1964 through 1968 has been the most turbulent for business activity that the practitioner has ever faced. The management problems of operating an office are becoming complex and draining away time and energy that the physician might otherwise direct toward providing better health care for patients.

To most physicians in private practice, the business side of his practice seems like it's "just one crazy thing after another." He has been asked by all of us to see and treat more patients, and to do so at less cost to the consumer. At the same time, he must meet rising operating costs caused by a variety of factors that will be explained. He must

expand his office facilities; he must employ more aides; he has been hit by a paperwork blizzard, and he is encountering numerous controls from many different governmental units.

TRENDS IN OFFICE MANAGEMENT PROBLEMS

At the present time we find that there are six significant problems that face the practitioner. The first is the demand for higher productivity. The evidence of this is everywhere, and it is most apparent to the private practicing doctor whose day just never seems to end. He is stretching his working time to the breaking point in many instances. Recently we have noticed that the demand for more health care has caused a reduction of the number of doctors that might otherwise be working and producing on a reduced scale. Senior doctors who used to semi-retire are now faced with the dilemma of either continuing full blast or dropping out altogether, and many of them are choosing the latter. We have seen young men reach the breaking point, too. Some quit private

(More on Page 716)



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- More Time for Patient
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- Identify Business Problems
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GIVE YOUR AIDE A PAY BOOST - - WHAT WILL BE LEFT?

Medical Aide Receiving \$5,000 a year	
Pay Raise: \$300 — a 6% increase	
Federal Tax on \$300 Raise	\$ 48
Increase Surtax	34
Higher Social Security Tax	13
Higher Cost of Living (4%)	200
Total Offset to Raise	295
Leaving out of a \$300 Raise	\$ 5

practice in favor of jobs with industry and a variety of groups that offer limited working hours. Typically they accept less money—you might safely say they are buying "time off."

Any doctor who has the responsibility of meeting a payroll, paying the landlord, and meeting other costs of operating an office is aware of the rapidly rising costs. He is concerned about inflation. Unfortunately, not all doctors are aware of the degree of change. Since 1964 the value of the dollar has slipped 13 cents. Satistical information tends to run two to three years behind and is like yesterday's fever chart. We do attempt to make projections and alert our clients as to what is happening, and most of this is on the gloomy side at the moment. Doctors know that there is more paperwork occurring in their offices and this problem is being handled with varying degrees of efficiency.

When Charles Wilson was Secretary of Defense in the Eisenhower Administration, he made the remark to a congressional committee that nothing of significance happens today in our society that is not followed by a piece of paper. This is especially true in medical practice, and the amount of paper has increased since Mr. Wilson's testimony 15 years ago. There are several reasons why the trend has accelerated in the past few years. For example, the large number of mal-practice cases nationwide cause many doctors to keep more detailed records for defensive reasons in the event of a lawsuit.

Through an evolutionary process the physician in practice has assumed an obligation to prepare report claims to third parties for payment of services. The volume of claims for Medicare, Medicaid and other insurance claims goes up with the greater case load. Failure to stay on top of insurance reports causes confusion and inconvenience to patients and loss of income to doctors.

Another paperwork factor that is less apparent is the increasing amount of general business activity. Payroll details and reporting are up significantly. The statements for services that the physician sends out to his patient have to be more detailed and sent on a regular cycle. When you examine all of the business aspects of private practice, you discover that almost every feature of its requires more record keeping and more reporting than was necessary a few years ago.

Along with the demands of higher productivity

comes the necessity for more facilities and equipment. If doctors are to become more productive, and apparently they must accomplish a degree of higher productivity each year, it is necessary to have more office space and have it better equipped. This requires more capital outlay by the practitioner. Coupled with demands of paperwork and more facilities is the need for more ancillary personnel. In the past three years it has been necessary to add at least one-half an employee per doctor to each practice if the practitioner is aware of change and wants to stay on top of the increasing workload. Many practitioners now need three full time employees. Ten years ago it was common for them to need only one aide each.

The last point is the increasing governmental controls. Most physicians are aware of the typical reports required by welfare agencies, HEW, and the like. A new factor in the lives of private practitioners as an employer is the Labor Department. As of February 1, 1969, the Labor Department applied wage-hour controls to any practice doing an annual volume of \$250,000. This doesn't as yet catch the solo practitioner, but it does cause headaches for members in group practice. These regulations have not been generally publicized, but it is only a matter of time before the Labor Department will enforce regulations on overtime, minimum wages, and increased record keeping that goes with employing people. We have recently recommended to our large group practices that they install either a time clock or have employees keep time sheets, and eventually all practitioners will have this added burden.

One final factor is the quasi-governmental control by hospitals, specialty organizations, and medical societies. They all make rules, require reports, attendance, and want a bit of the doctor's time.

GP's TYPICAL WORKING WEEK

During 1968 our general practice client spent 35 hours a week working in his office, 12 hours working in the hospital, and 10 hours of commuting or travel time, for a total of 57 hours in his average working week. Our typical client gets about three weeks vacation a year and he is away for postgraduate training and professional meeting time about one week. He is working about 48 weeks a year. When the rest of society is trying to reduce the work week, it doesn't seem that we can offer him much in the way of equal opportunity for leisure and time off.

In fact, the expectation is that we will ask him to increase his hours in the office and the hospital. Rather dramatic results could be achieved by each doctor lengthening his office hours one-half hour per day across the whole United States. A sizable number of additional patients could be seen. But how do you tell a man who is now working 57 hours a week that he should move his work week

to 60 hours when the rest of the society wants to go the other way?

TRENDS IN INCOME-OVERHEAD-PROFIT FOR THE PERIOD 1947-1968

We have records that date back to 1939, but the most meaningful data began to be accumulated after World War II, beginning in 1947. We have selected data accumulated between then and 1968 as an illustration of what has happened to costs and fees. During this period we see that the cash receipts, the gross income of our clients, on an average has advanced 51%, or 2.3% annually. Office overhead has increased a bit more – 53% or 2.4% annually, while Net Professional Profits rose 48%, or 2.2% annually. Since 1947 the country has experienced a 75% increase in prices.

The most significent changes that occurred between 1964 and 1966 were among overheads that expanded at the rate of 8% annually. Business went up at the rate of 7.5% annually; cash receipts advanced 7% annually; and profits increased 6.6% annually. In fact, the practitioners were actually falling behind, caught in the general cost-price squeeze. We anticipate that when our 1968 data is tabulated, the rate of increase in operating costs will be greater than it was in the last period that we analyzed.

TRENDS OF OPERATING COSTS

Reviewing the major categories of operating costs we reach conclusions along these lines:

Salaries. Salaries are advancing rapidly and the trends tell us to anticipate even more upward change. Employees per practicing physician are not only increasing, but also must be paid more, and practitioners must raise their pay at a faster pace than was customary in the past. Dramatic changes have occurred in salaries of hospital personnel and to some extent there is a reaction to this in the practitioner's office that must be understood and the demand for comparable pay must be recognized.

Rents. There was a time when a practitioner's rent was not a sizable part of his overhead, but this is changing. Today adequate facilities cost about \$7 per square foot. The typical practitioner needs a bit over 1,000 square feet, and this means that his annual outlay for rent is about \$7,000 a year.

Clinical Supplies. Our records show that in this area the practitioner is doing quite well. He is holding the line percentage-wise and in many instances there is actually a percentage decline for clinical supplies. This may be caused by a change in practicing habits, with many of the older physicians fading out of the picture and the younger ones writing more prescriptions. There is an increased use of disposable supplies which may reverse the controlled trend.

Clerical Supplies. There has been a sharp increase in the expenditure for paper supplies, and

inasmuch as paper is cheaper than labor, we feel this is a justified area for a rising cost index.

Convention, dues and journals. In years gone by this was not treated as a special category, but because of the importance given to attendance at professional meetings, belonging to professional societies and subscriptions to medical journals, we now recognize this area of costs as important. Travel expense is up because doctors travel more. The actual cost per trip has not changed significantly, and we marvel at the way many professional organizations have been able to maintain their dues structures without asking for an increase. Journals and book costs tend to reflect the relative change in the general price index.

Telephone. The increased size of facilities needed by each physician, and the demand of patients to call the medical office have increased the number of telephone facilities installed and used in each practitioner's office, and this is becoming a significant part of the overall cost picture.

Auto Expense. Statistically this seems level, but this is not a true representation of what is happening. Ten years ago it was fairly common for many practitioners to claim the full cost of at least one automobile as part of office expense. In recent years IRS has forced taxpayers to reduce part of a doctor's professional car costs for personal use.

Fees. This particular cost item shows some increase, but some interesting changes have occurred to control fee costs. Things that used to be charged as salaries and supplies now show up as fee expense. For example, in internal medicine 10 years ago there was a sizable number of practitioners who employed a lab technician and operated small laboratories in their offices. Today an internist is less apt to have his own laboratory because he cannot get the skilled personnel necessary to operate it. He finds that he can send out the laboratory work at a reduced cost to the patient, and he often gets more information for the dollar he is spending. Frequently it is a better deal for the patient and the doctor.

Ten years ago many general surgeons paid the assisting surgeon, but this cost is shifting as insurance companies recognize the assistant and pay him directly. Also, most general surgeons and assisting surgeons have complied with the ethical requirements of not splitting fees. The assisting surgeon now bills directly for his services. Fee expenses for accounting, legal, management services and tax reporting are rising.

Statistically fee expenditures are creeping up, but it should be remembered that part of the increase is due to the way doctors are practicing, and accounting classifications that shift costs.

Taxes. There is a sizeable increase in business taxes that are aside from the individual's income taxes and personal tax items. We have in mind here the taxes that he pays on employee payrolls,

PHYSICIAN'S NET EARNINGS GO UP - - WHAT WILL BE LEFT?

Physician Earning \$30,000 a year	
1968 Raise: \$2,000 — a 6.6% increase	
Federal Tax on \$2,000\$	720
Increase Surtax	450
Higher Cost of Living (4%)	
Total Offset to Raise	2,370
Physician's financial Fortunes go down LOSS \$	370
(PROFESSIONAL MANAGEMENT CORP. FIGURES)	

unemployment compensation, personal property and the like. The Social Security taxes alone are becoming sizable, too, and are directly related to the increased costs and size of payrolls.

Insurance. A sharp increase can be noted in insurance costs. Startling increases in the cost of mal-practice protection have occurred in all fields of practice. Mal-practice insurance premiums are the most rapidly advancing cost items of private practice.

Even more important may be the trend toward having senior doctors and others cut off from coverage altogether. Many casualty insurance companies are withdrawing this type of coverage because their losses are too much. The companies still selling mal-practice coverage are demanding the right to screen out doctors because of age, foreign training and specialty fields where the risks are high. The economical implications to the practitioner are serious and some hard decisions on whether to practice at all may be necessary for uninsured physicians.

Auto insurance is rising, too, and so is all casualty insurance in the office, such as workmen's compensation, office contents, employee bonds and building risks. In some places an office can be located so that it is one of the high risk areas—particularly inner-city offices.

COLLECTION PROBLEMS GROW

Our statistics show that collections peaked about 1958 when our clients averaged 97%. By 1963 the collection percentage dropped to 95.6% and we anticipate more decline for 1968 when all of the data is tabulated.

The collection procedures in many offices are based on the fundamental concept that the patient wants to pay his health care bill. A new attitude may be entering the picture that will cause us to re-evaluate the whole collection system. If a sizable number of patients switch to an attitude of indifference toward paying doctor bills, collections will drop. At the present time we feel the paper work blizzard is the primary cause of collection losses, but an "I don't want to pay" attitude may be creeping into the picture and complicating things.

PROBLEMS AIDES HAVE

Perhaps the person who is hardest hit of all with the paper work blizzard is the office aide,

whether she is a nurse or a secretary. We want to point out that not all of the paper work consists in governmental forms, either. We mentioned that doctors keep better and more complete clinical records. A sizeable number of patients have some sort of insurance coverage, many patients have several policies covering loans, and doctors have gradually assumed the obligation to prepare these claims. Claims are fairly easy items to sluff off and get buried by both doctors and aides. There should be careful controls established to prevent this. The aide with a special knowledge and skill at handling this paper work is a particularly valuable employee.

More detailed record keeping is making demands on her in other ways. As business constantly increases there are more checks to write, it takes more time to reconcile a bank account, to do a payroll, to pay the bills. Also, the office consumes more supplies and so there is more purchasing, and it requires time to take care of these growing activities. Filing time increases — these papers must be put somewhere, and when the practitioner has more business he has more bookkeeping.

A SIGNIFICANT THING to note is that in many instances it is possible for the practitioner to see and treat the patient faster than his aides can do the proper work necessary to record the treatment and the rest of the transactions involved. This may be a bit difficult to comprehend on the part of a doctor who is working 57 hours a week.

Another point is that telephone traffic is becoming unbearable to some medical aides. With the shortage of doctors it is possible for a girl to spend a good portion of her day answering telephone calls from patients who want to get in to see someone and can't find a doctor. She is faced with the problem of tactfully explaining to people that her doctor cannot see them, and she often cannot refer the caller to any doctor. It's frustrating and hard work. Some knowledgeable practitioners have recognized that phone duty probably is the most exhausting job in the medical office today, and have solved the problem by rotating aides at the reception desk.

INFLATION EATS AWAY at the pay of aides as it does at everyone else's. Most aides work for money in the paycheck and not for a fringe benefit. Full employment of our economy is causing lots of employee turnover and this is costly when the doctor fails to recognize it, lets a skillful person go and has to replace her with one without experience. Small and frequent raises seem preferred by the aides.

One last point is the hours medical offices are open. Medical aides dislike a five and one-half day week, and they don't want to take their vacation when the doctor takes his. Saturday morning office hours are a problem for all employers nowadays.

TRENDS IN FEES

Let's turn to the subject of fees. The typical charge for an office call has risen 45% to 49% over the 1947 fee. Office charges by general surgeons have increased at a much slower rate than charges by medical specialists. Most doctors are aware of the activities of internists, pediatricians, and the like, to catch up with relative income as compared to surgical activity. Surgeons' incomes have been edging up and internists' incomes are closing the gap.

Prices for physical examinations for pediatrics have increased by 37% in a 21 year period, 37% for internal medicine, 47% in the field of general practice. These are examinations without any additional charges for laboratory work, EKG's and other studies.

Charges for surgical procedures have advanced the least of all professional fees since 1947. For example, an appendectomy charge in 1968 was up only 23% over the same charge in 1947, if the operation was performed by a general surgeon. If the operation was performed by a general practitioner, the fee was only 24% greater.

The cost of having a baby is up markedly. Today a typical OB specialist charges \$200, and this is 132% more than he was charging in 1947.

The general practitioner has advanced his charges for obstetrical care even more. Today he charges \$150 for a delivery, 158% more than he was charging in 1947. The custom for charging for OB cases is often different now than it was 20 years ago. General practitioners, and many specialists, used to make a charge for the delivery and itemize pre- and post-natal visits as office calls. Today specialists and many GP's usually make a package charge. We do not have the information to factor out the variations of charging, but the high percentage increase can in part be accounted for by a changing custom.

WHAT'S HAPPENING TO MONEY

Doctors, as many others, have reacted to inflation with mixed emotion. The acceleration of changing money values may necessitate the creation of new procedures of business office management. Since 1947 the cost of living has increased 75%, and the purchasing power of the dollar is down 87%.

ONE OF THE MAJOR problems that medical practitioners face is inflation. When we have one or two percent inflation, economists call it creeping inflation, 3 to 4% is a growing inflation, and when we jump to 4 or 5% a year, as in 1968 and currently, they call it galloping inflation. At the 1968 rate of inflation the practitioner would have to realize about a 10% increase in his net

earnings to stay even. Most of this can be attributed to the progressive tax rates of our Federal tax structure, and still we haven't taken into account the progressive tax rates of many state and local municipalities, which are spiraling.

The illustration in Box A gives an idea of what an aide has left if she gets an annual pay boost. This aide receives a salary of \$5,000 a year. Suppose in 1968 she received a boost of \$25 a month, or \$300 annually, an increase of 6%. At first glance it would seem she is getting ahead. Yet after analyzing her case, it is obvious that with increased taxes on her raise, plus surtax, plus Social Security taxes, and a conservative 4% inflation advance, she had a balance of \$5 left for the year. This can hardly be labeled "getting ahead." It barely puts her ahead of where she was the year before.

The illustration in Box B shows what happened to a physician who was earning a net of \$30,000 a year and realized \$2,000 more profit in 1968 over the previous year, the 6.6% increase we mentioned earlier. Higher Federal tax on the \$2,000 plus the surtax, plus the loss of purchasing power on his earning increase actually resulted in his financial fortunes going down last year by \$370.

A PREDICTION OF "U.S. News and World Report" illustrates what may occur between now and the end of the century. In the year 2,000 it may cost \$630 for a day in the hospital, a new car may cost \$9,900, a hair cut may cost \$10, a machine made man's suit \$270, the food bill for four people \$112 per week, a year of college in a public institution \$6,000, a modest home for a typical American family \$86,000 and having a baby \$640. Obviously earnings will have to inflate, too.

Inflation is a popular thing to the majority of people. Because of it businessmen can cover up mistakes and show stockholders things are advancing. The laboring people seem to demand more money each year and labor leaders like to show their members that they have a greater annual wage. Politicians like to inflate the dollar because it covers up political errors and makes repayment of public debt possible with cheaper dollars. In fact, we all like to feel we earn more. The concept of inflating money is a major handicap to increased productivity of health care and ultimately forbids controlling costs for consumers and the accomplishment of a reasonable professional profit by practitioners.

Recently, as a patient, I asked my doctor what he felt was the most significant financial change that has occurred since he began his practice. He thought for a moment and said, "The first year I practiced, my gross income was about \$3,000.00. Today, it costs more than that to pay my office overhead each month!"



Hilliard Jason, M.D., director of the Office of Medical Education Research and Development at Michigan State University, leads a tour of the MSU School of Human Medicine's facilities. In his party are part of the group which attended the Seminar on Medical Education for Science and Education Writers, held on the MSU campus in May and sponsored by MSMS, the Michigan TB and Respiratory Disease Association and MSU.

MSMS Seminar Informs Medical Writers Of Striking Changes in State's Medical Schools

BY JUDITH MARR MANAGING EDITOR

Approximately 30 of the state's education and science writers have a new awareness today of the challenges being put to Michigan medical education. Their enlightenment is due to a full-day's program co-sponsored by MSMS early in May—the annual Seminar in Medical Education for Science and Education Writers—which took place at Michigan State University's Kellogg Center.

Other sponsors were the Michigan TB and Respiratory Disease Association and Michigan State University.

Today's challenges to medical education, university spokesmen told the writers, include the necessity of creating a social consciousness among medical graduates and integrating social science into medical education, increasing the efficiency of medical teaching, shortening the period of medical training, creating more black doctors and decompartmentalizing the medical curriculum.

Describing how those challenges are being met by their schools were Hilliard Jason, M.D., Ed.D., professor and director, Office of Medical Education Research and Development, Michigan State University; Paul Rondell, M.D., associate professor of physiology, The University of Michigan, and Joseph Hess, M.D., Director of Research in Medical Education at the Wayne State University School of Medicine.

ADDRESS LARGER PROBLEMS

In opening remarks, Andrew D. Hunt, Jr., M.D., dean of the MSU College of Human Medicine,

talked of the need for the medical profession to address itself to "problems of far greater width than mere applied biology."

"The training of more doctors to do the same thing that has been done in the past will simply make it easier for people in the suburbs and nothing will happen in the wider problems of health," said Doctor Hunt.

Doctors must be interested in doing something for people in the inner city and Upper Peninsulalike isolated areas, he said. They must have compassion and interest in the great danger in the disparity between the haves and havenots.

"What we need is a different kind of physician," he said. "I am concerned that the numbers game is drowning out the need in this country for the integrating of the social sciences into the medical curriculum."

MSU PLANS 'INTEGRATION'

The key to the new MSU College of Human Medicine's innovative curriculum, according to Doctor Jason, is "integration" — of pre-clinical and clinical studies, of separate departments into one Human Biology Sequence curriculum, of medical school with community and whole university and of teaching by faculty with teaching by students of students and by students by themselves, with the aid of new teaching methods.

Students at MSU study medicine, according to Doctor Jason, by learning of the whole human being's social, emotional and health problems in a curriculum following development from conception to death; they do much of their study in community facilities because MSU is purposely

keeping its own hospital teaching facilities small; they are on the curriculum and evaluation committees and all committees relating to instructional planning and they have little of their time scheduled in class so they may acquire the ability to learn on their own.

The MSU medical college is also studying ways to help prospective doctors learn better evaluation procedures, is limiting the departments under the college, to draw on the facilities of other university departments and is paying much attention to developing new teaching aids, said Dr. Jason.

Doctor Rondell described the U of M's threepart program to recruit undergraduate black students into medicine: a summer residency program of orientation, flexible scheduling to allow study of fewer courses at a slower pace and a compensatory program for promising undergrads preparing them through an extra year's remedial work to enter the regular medical education curriculum.

U-M COMPLETELY REVISING

Doctor Rondell also outlined the university's complete revision of its curriculum, begun two years ago. It includes the introduction of two courses in clinical medicine which comprise the bulk of freshman and sophomore studies, an entirely clinical junior year and a senior year devoted to electives.

The objects of the new curriculum, he said, are to reduce the traditional course work by 40 percent, allowing for more practical instruction; providing patient contact much earlier; teaching the student the relationship of doctor to patient and decompartmentalizing the curriculum.

Wayne State, reported Doctor Hess, has a fourpart program for black students, involving remedial work, tutoring, and emphasis on a student's promise rather than his grades and test scores for admittance.

NEW WAYNE CURRICULUM

Beginning with 1970's entrants, Doctor Hess continued, WSU will begin a new curriculum with a first-year focus on the normal functions of the human body; a second-year emphasis on the abnormal, or what occurs when disease attacks the normal; third year study through clerkships in major clinical disciplines and a fourth year that is largely elective.

The study of basic sciences will be interwoven each year, while behavioral sciences will be included in the first, second and fourth years.

Persons in attendance at the seminar included representatives of the Associated Press; Detroit, Lansing and Ann Arbor papers; free lancers, medical and journalism students and communicators from hospitals in Detroit and Lansing.

PROBLEMS OF SUCCESS

Cheves McC. Smythe, M.D., Chicago, associate director, Association of American Medical Colleges, luncheon speaker, suggested that medical education's problems are due to the fact that it has been so successful in the past; and because the 100 medical schools of the country have secured a monopoly on their product and are now suffering the same problems undergone by all monopolies that are curtailed. The major result, he predicted, is that medical education will stop being as self-determining as it has been in the past, and will come under the power of the changes being wrought throughout universities, under the power of public wants and computerized services.

Afternoon sessions of the seminar were devoted to tours of the facilties of the new MSU College of Human Medicine and explanations of its teaching techniques.

They were followed by the Michigan TBRD Association's Yates Memorial Lecture, this year delivered by William H. White of New York City, former editor of *Medical World News* and founder of the new *Family Health* magazine.

Mr. White suggested that the country lately has been in the midst of a revolution in medical communication, with the medical news media changing the face of the medical professional's life and bringing much more communication between leading physicians and the public.

"The key point for medicine is that physicians will be called upon more and more to provide information to the public," said Mr. White. "The public wants it and the enlightened medical leader more and more is recognizing that there is something more than the traditional behind-the-closed-door, doctor-patient relationship; they have a much greater responsibility to try to reach the individual before he comes in as a patient."

William H. White of New York City, former editor of **Medical World News**, describes his experiences in founding the new **Family Health** magazine, which he now edits, to the audience at the Seminar in Medical Education for Science and Education Writers. He delivered the annual Yates Lecture sponsored by the Michigan Tuberculosis and Respiratory Disease Association.



WHAT'S SO WEAK ABOUT THE WEAKER SEX?

OFTEN... HERLOWER G.I.TRACT

Psycho-abdominal Distress: Frequently Female

Women aged 15 to 45 appear to be more prone than men to bloating, cramping pain of stress-related intestinal disturbances such as irritable or spastic colon. 1.2

Frequently Recurrent

In the experience of many physicians, women are more likely to reappear time after time with repeated complaints of lower G.I. distress.

Requiring Definitive Therapy

Often needed is therapy adequate to control <u>both</u> the somatic and the emotional components of psycho-abdominal complaints.

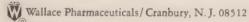
Definitive Dual Therapy

'Milpath' contains a proven synthetic anticholinergic useful for relieving hypermotility, spasm, and hypersecretion of the gastrointestinal tract.

In addition, 'Milpath' provides a time-tested tranquilizer for mild but effective anti-anxiety action.

With Flexible Dosage

- 'Milpath'-400 (meprobamate 400 mg. + tridihexethyl chloride 25 mg.) Usual adult dose: 1 tablet *t.i.d.* and 2 at bedtime.
- When less tranquilization is required: 'Milpath'-200 (meprobamate 200 mg. + tridihexethyl chloride 25 mg.)

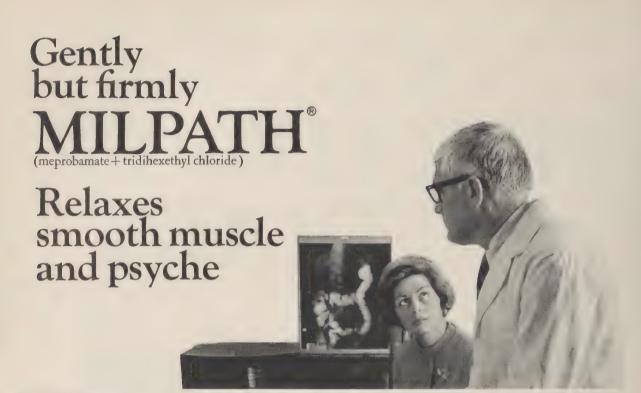




gently but firmly

MILPATH®
(meprobamate + tridihexethyl chloride)

relaxes smooth muscle and psyche



Usual Adult Dosage

One 'Milpath'-400 tablet, three times a day at mealtimes, and two at bedtime. For greater anticholinergic effect, two 'Milpath'-200 tablets, three times a day at mealtimes and two at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.

Indications

Useful in organic and functional disorders with hypersecretion and hypermotility of G.I. tract, especially when accompanied by anxiety, neurosis, or tension states. Should be used as an adjunct to all other therapeutic measures.

Contraindications

Tridihexethyl chloride: Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus: organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention.

Meprobamate: Previous allergic or idiosyncratic reactions to meprobamate.

Precautions

Tridihexethyl chloride: Use cautiously in elderly males (pos-

sible prostatic hypertrophy).

Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

Side Effects

The following side effects of components may occur with 'Milpath'.

Tridihexethyl chloride: Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral

doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness.

Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated

Supplied

In two strengths:

'Milpath'-400: Yellow, scored tablets.

'Milpath'-200: Yellow, coated tablets.

Before prescribing, consult package circular.

References

1. Harrison, T. R., et al.: Principles of Internal Medicine, Fifth Edition, New York, The Blakiston Division, McGraw-Hill Book Company, 1966, p. 1019. 2. Bockus, H. L.: Gastroenterology, Second Edition, Philadelphia & London, W. B. Saunders Company, 1964, Vol. II, p. 729 et seq. (1928A01J)



Let's be specific about Campbell's Soups... and <u>reducing diets</u>



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

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mately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to: Campbell Soup Company, Box 265, Camden, N. J. 08101



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Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg

The new mother needs time...
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband...
and for herself as well...
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.



Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication-Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968^{1,2} estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortali	ty Rates	Hospitalization Rates (Morbidity)	
	Age 20-34	Age 35-44	Age 20-44	
Users of Oral Contraceptives Non-Users	1.5/100,000 0.2/100,000	3.9/100,000 0.5/100,000	47/100,000 5/100,000	

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contra-

ceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions-Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither con-

firmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T³ uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

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THE KEYNOTE ADDRESS at the Public Forum on Arthritis was delivered by MSMS President James J. Lightbody, M.D., who is also the medical director for the Michigan chapter of the Arthritis Foundation. More than 8,000 requests were received for tickets and 1,600 attended the May forum.

Arthritis Foundation, MSMS Draw 1,600 To Public Forum



A GROUP PORTRAIT of Arthritis Forum participants includes, from left, James J. Lightbody, M.D.; Robert Larsen, M.D., assistant professor of surgery at WSU and a forum speaker; Jerry J. Walsh, New York City, of the American Arthritis Foundation; Sidney Chapin, M.D., Detroit, forum coordinator; Ray Hulce, president of the Michigan Arthritis Foundation; J. N. Schaeffer, M.D., Detroit, moderator; Harry O. Ingberg, M.D., assistant professor of physical medicine and rehabilitation at the WSU School of Medicine, another speaker, and H. Ross Hume, M.D., of the Wayne County Medical Society.



MORE THAN 1,600 jammed the Dearborn Youth Center for the Public Forum on Arthritis sponsored jointly by MSMS, the Wayne County Medical Society, Michigan Chapter of the Arthritis Foundation and THE DETROIT NEWS. A followup forum for those unable to attend the first one was held in June, and other public forums on other topics are planned for later in 1969 by MSMS, WCMS and THE DETROIT NEWS.





The Fourth Annual Conference on the Medical Aspects of Michigan High School Sports drew about 200 team physicians, coaches, trainers and principals to the MSU Kellogg Center. The popular event was co-sponsored by MSMS and MSU.

AT LEFT — Recommendations for protective sports equipment were made at the 1969 Conference by James S. Feurig, M.D., MSU team physician. Two young coaches examine football helmets after the lecture.

AT RIGHT — Gerald A. O'Connor, M.D., right, chairman of the MSMS Committee on the Medical Aspects of Organized Athletics, presided at the conference. Two major addresses were givn by Fred L. Allman, Jr., M.D., left, of Atlanta, Ga., president of the American College of Sports Medicine. News of the conference was sent to several major national magazines by James Totten, Center, MSU editor.

BELOW — The 225 registrants enjoyed the luncheon address by MSU Football Coach Duffy Daugherty who gave humorous insights into training and coaching.







COACHES AND TEAM physicians were keenly interested in the exhibit of smoking and health literature presented at the conference by the Michigan Tuberculosis and Respiratory Disease Association. Discussing one of the bulletins is Charles Davenport, M.D., right, Saginaw, member of MSMS sponsoring committee, and Edward Reynolds, M.D., Williamston team doctor.



ALLEN W. BUSH, center, director, Michigan State High School Athletic Association, described "The Physician's Role in High School Athletics." After the conference, he discussed possible future committee eforts with MSMS Committeeman R. H. Evans, M.D., left, Sturgis, and R. O. Maher, Sturgis coach.



W. DONALD WESTON, M.D., left, of the MSU College of Human Medicine, who described "The High School Athlete and His Emotions," confers further with Jack Koch, center, Jackson coach, and MSMS Committeeman R. C. Buslepp, M.D., Jackson.





DETROIT SMOKERS WISHING to kick their habit and numbering 1,750 were drawn to a series of smoking withdrawal clinics sponsored this spring by the Michigan Cancer Foundation. Speakers such as Arthur Weaver, M.D., left, chief of Head and Neck Services, and Frederick N. Tallmers, M.D., cardiologist, from the Allen Park VA Hospital, both WSU assistant professors, drew such crowds that the number of clinics was expanded from three to six. More clinics are planned in the fall and followups on spring participants are scheduled for August. The clinics were initiated as a part of the April Cancer Control campaign. Doctor Weaver led five clinics, aided by Donald Smith, M.D., also a VA Hospital surgeon, and Doctor Tallmers spoke at the first clinic, in Greenfield Village.

CAPITOL DOME TOWERS over members of the Michigan Association of the Professions in Washington, D.C., for their annual Congressional Breakfast and Visitations at the Rayburn Building. From left in lower row are James Imboden, Chicago, AMA field representative to Michigan; Robert J. Mason, M.D., MSMS president-elect; Elmer J. Manson, Lansing, A.I.A, MAP president; Ross V. Taylor, M.D., Jackson, chairman of the MSMS Council; Charles Chamberlain, U.S. Congressman from Lansing; Helen Menton, MAP executive assistant; Ralph Wills, MSMS Community Relations director; and Charles H. King of Detroit, MAP vice president. In top row are Donato Sarapo, M.D., Detroit, chairman of MD-PAC; J. Russell Brink, M.D., Grand Rapids; Gene Duckworth, M.A., Mt. Pleasant; Richard Adams, East Lansing, of the Michigan Education Association and Hugh W. Brenneman, executive director of both MSMS and MAP.





BUSY TAKING NOTES at the first MARMP-Michigan Heart Association-sponsored seminar for physicians are, from left, George W. Sippola, M.D., Highland Park General Hospital; Nicanon M. Guevvara, M.D., Allen Park V.A. Hospital; Helen Lausz, M.D., Allen Park V.A. Hospital and John F. Tannheimer, M.D., Ionia County Memorial Hospital. "Decision Making for the Acute Coronary" was the subject of the seminar, which included 22 subjects taught by a faculty of 16 Michigan physicians. Over 80 Michigan doctors attended.



SEMINAR BREAK PROVIDES time for Larry S. Kelly, M.D., Tawas City, left, and Ralph L. Brandt, M.D., chief, Cardiac Catheterization Unit, St. Joseph Mercy Hospital, Ann Arbor, to further discuss topic of Doctor Brandt's seminar class.

A QUESTION FROM Internist Edmon W. Fitzgerald, M.D., Port Huron, right, occupies Gerald M. Breneman, M.D., chairman of the Henry Ford Hospital Coronary Care Unit and chairman of the Heart Association's Coronary Care Unit Committee, which planned the seminar. Doctor Breneman also taught two seminar classes.

HEART ASSOCIATION, MARMP SPONSOR PHYSICIAN'S SEMINAR AT PROVIDENCE HOSPITAL





ARMED WITH SIGNS and collection buckets, teams of nurses and students from Wayne State University's School of Medicine hit the streets three days in May and collected nearly \$16,000 to enhance patient comforts at the Detroit General Hospital. Slated to be an annual affair, the fund-raiser was launched with a rally in downtown Detroit's Kennedy Square. Participants included WSU President William R. Keast; Alexander Walt, M.D., WSU Associate Dean for Hospital and Clinical Affairs and George Pickett, M.D., Public Health Director for Detroit and Wayne County.



AN HONORARY MEMBERSHIP in the Michigan Public Health Association was extended by President Dempster to Winston B. Prothro, M.D., M.P.H., F.A.C.P.M., Grand Rapids, left, director of the Kent County Health Department and Community Health Service. Doctor Prothro is a MSMS member.

A HIGHLIGHT OF the 48th annual meeting in May of the Michigan Public Health Association, staged in Flint, was the presentation of a distinguished public service award by MPHA President Andrew T. Dempster, Detroit, right, to John J. Hanlon, M.D., Assistant Surgeon General of the Public Health Service and deputy commissioner of Consumer Protection and Environmental Health Service of HEW. Doctor Hanlon was Public Health Director for Detroit and Wayne County until September, 1968 and was keynote speaker for the MPHA meeting. (Photo Below)





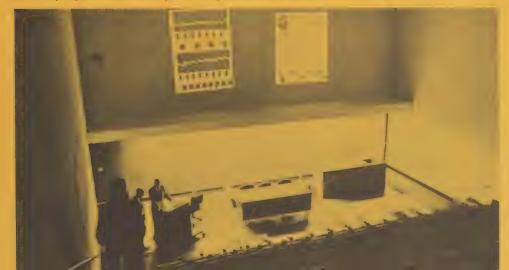
A GROUP PORTRAIT taken at the recent Annual Dinner Meeting of the Michigan Diabetes Association in Ann Arbor, includes the physicians who are new and continuing members of the MDA Board of Directors, from left, William E. Rush, M.D., Detroit; Jack A. Litwin, M.D., Detroit; Herschel A. Schulman, M.D., Southfield;

John B. Rowe, M.D., Flint; James J. Aiuto, M.D., Grosse Pointe; Marjorie Peebles-Meyers, M.D., Detroit, vice president; Fred W. Whitehouse, M.D., Detroit, president; Walter A. Johnson, M.D., Detroit; John B. Bryan, M.D., Royal Oak, and Michael Grishkoff, M.D. and Henry D. Kaine, M.D., both of Detroit.



THE DIABETIC'S ROLE in the management of his own disease was stressed by Donell D. Etzwiler, M.D., left in photo at left, keynote speaker for the Michigan Diabetes Association's annual meeting. A comprehensive educational program should be part of the initial and follow-up care of every diabetic patient, stressed Doctor Etzwiler, here talking with Henry D. Kaine, M.D., center, and Walter L. Anderson, M.D., both of Detroit, members of the MDA Board of Directors.

AUDIO-VISUAL AIDS in U-M's new Towsley Center are capable of any task a teacher is innovative enough to require of them. Here, in the Sheldon Lecture Room, are a 16mm motion picture projector, a lantern-slide projector, and a pair of 2x2 projectors. All can be used singly or in combination and can be controlled by the speaker at the podium as well as the projectionist. Each of the 144 seats has a plug-in stethophone through which doctors can hear heart sounds associated with disorders illustrated by EKG slides overhead. Four television monitors soon will complete the array. In the Dow Auditorium there are similar projectors, plus a television system which projects live or taped images onto a 15-by-20-foot screen.





KEYNOTE SPEAKER FOR the MSMS-sponsored annual Medicine-Religion Workshop at the East Lansing head-quarters, was William N. Hubbard, Jr., M.D., dean of the University of Michigan School of Medicine. Doctor Hubbard discussed "Gut Issues in Medical Ethics."

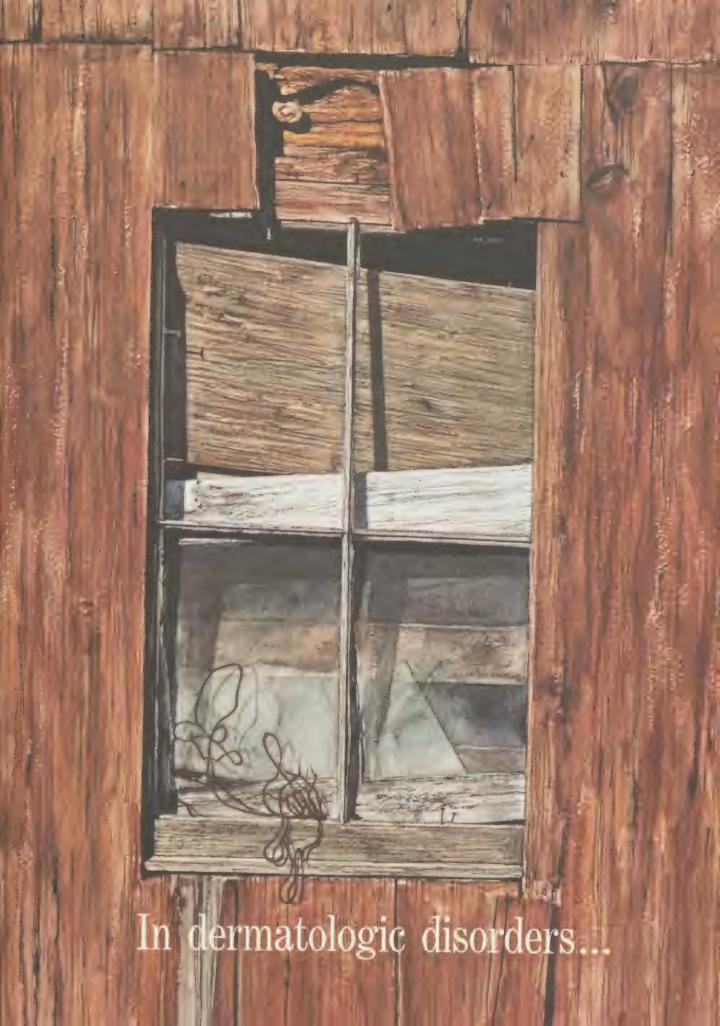


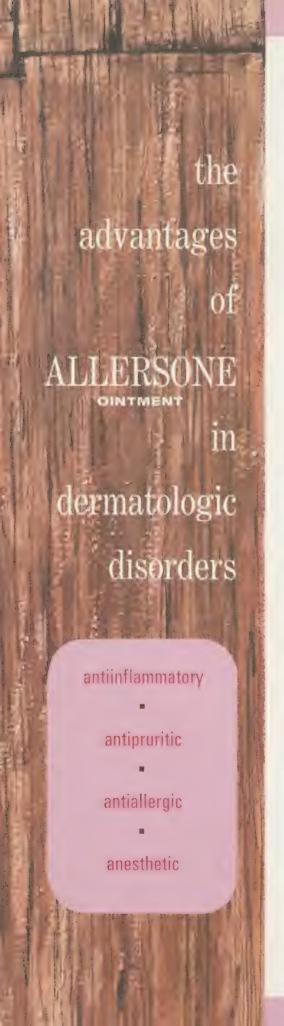
MSMS Sponsors Medicine-Religion Workshop

DOCTORS, CLERGYMEN, STUDENTS were in attendance at the annual Medicine-Religion workshop, an all-day event which included reports from county medical society medicine-religion chairmen and from The Rev. Dr. Paul B. McCleave, LL.D., head of the AMA's medicine-religion committee. Typical of the groups which attended the session were, from left, Richard Bennink, Holland, student at Western Theological Seminary; Maurice H. Chapin, M.D., Millington, Tuscola County Medical Society medicine-religion chairman; Arthur DeBoer, M.D., Grand Rapids, Kent County Medical Society medicine-religion chairman; The Rev. George Henriksen of Millington, guest of Doctor Chapin, and The Rev. David Voorhees of the Lansing Area Council of Churches.

MSMS's DELEGATION to the national AMA meeting this month in New York paused for a portrait at a recent meeting at MSMS when they decided on resolutions to place before the AMA House. From left'are Paul T. Lahti, M.D., Royal Oak; Joseph A. Witter, M.D., Rochester; Sidney Adler, M.D., Detroit; James C. Danforth, Jr., M.D., Detroit; Bradley Harris, M.D., Ypsilanti; Donald N. Sweeny, Jr., M.D., Detroit; Otto K. Engelke, M.D., Ann Arbor; Harold A. Furlong, M.D., Pontiac; George W. Slagle, M.D., Battle Creek; John W. Moses, M.D., Detroit; John J. Coury, Jr., M.D., Port Huron; Harold F. Falls, M.D., Ann Arbor, and John R. Heidenreich, M.D., Daggett. Doctor Sweeny is the chairman. Several delegates were unable to attend this planning meeting.







In the Management of common dermatologic disorders, Allersone provides more than symptomatic relief for your frustrated patient. Because Allersone combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

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for effective topical management

COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain—while hydrocortisone reduces inflammation—in a water-washable vehicle—no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.



In the complex picture of moderate to severe anxiety...



there is a <u>new</u> reason for prescribing Mellaril (Thioridazine HCI)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: Central Nervous System-Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. Autonomic Nervous System-Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. Endocrine System-Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. Skin-Dermatitis and skin eruptions of the urticarial type, photosensitivity. Cardiovascular System-Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. Other-A single case described as parotid swelling.

Mellaril[®] (Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression





...now fast relief of hay fever symptoms with

When pollens fly, just one or two squirts of NTz in each nostril, followed in a few minutes by a second spraying, shrink swollen nasal passages almost on contact. And breathing comfort follows. The anti-histamine component of NTz helps combat the allergic reaction and lessen rhinorrhea, sneezing and itching; its antiseptic wetting agent promotes rapid spread of components.

NTz Nasal Spray affords the well-known benefits of Neo-Synephrine® in a carefully balanced formula which includes:



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Neo-Synephrine® (brand of phenylephrine) HCl, 0.5% (adult strength), decongestant

Thenfadil® (brand of thenyldiamine) HCI, 0.1%, antihistamine

Zephiran® (brand of benzalkonium as chloride, refined) CI, 1:5000, antiseptic wetting agent

Treatments with NTz should be repeated every three or four hours as needed. NTz is for temporary relief of nasal symptoms and overdosage should be avoided. Available in squeeze bottles of 20 ml. and 1 oz. bottles with dropper.

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Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial injection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and

may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. Kidney—dose-related rise in BUN. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Intracranial—bulging fontanels in young infants. Teeth—yellow-brown staining; enamel hypoplasia. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



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After 30 years of clinical use ... still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression. Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative,
15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.),
30 mg. (½ gr.); Elixir, 30 mg. per 5 сс. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)]
15 mg. (¼ gr.), 30 mg. (½ gr.).

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Her urinary tract infection reveals itself through pain and discomfort.

While the pain and discomfort of a G.U. infection are anything but pleasant, the patient may be luckier than she realizes. That burning sensation (and/or frequency, urgency, dysuria) is a usually reliable sign of a urinary tract infection. And it's her good fortune that her infection won't go undetected...or untreated.

Azo Gantanol® therapy usually provides analgesic action within one-half hour, while control of the infection begins within two hours. Azo, a specific urinary analgesic, soothes inflamed mucosa to give symptomatic relief. At the same time, the antibacterial component, Gantanol (sulfamethoxazole), achieves therapeutic levels in the blood and urine, with diffusion into interstitial fluids. Azo Gantanol - a good choice when urinary tract infection reveals itself through symptomatic distress.

Before prescribing, please consult complete product information, a summary of which appears on opposite page.

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCI.)

Azo for the pain Gantanol® (sulfamethoxazole) for the pathogens

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed. Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets morning and evening. How Supplied: Tablets, bottles of 50.



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ANCILLARY

NIH GRANTS **FUNDS TO** HARPER HOSPITAL

A new grant of \$14,795,642 has been awarded to Harper Hospital by the National Institutes of Health. The funds are for the construction of a new nine-story 348-bed teaching hospital and to renovate the existing hospital. The project will provide a total of 557 beds for clinical instruction and will support the WSU Medical School enrollment increase of 83 students, bringing the entering class to 208 students.

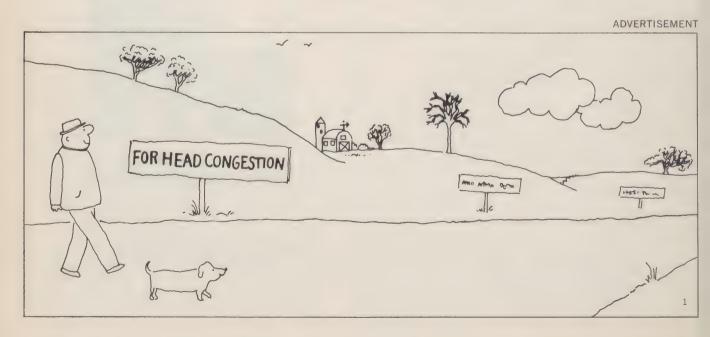
MARMP Advisors Okay Cancer Program, Change Some Personnel

The Regional Advisory Group, the top decisionmaking body within MARMP, approved at its May 23 meeting, a "Regional Cooperative Cancer Management Program." The Cancer Program developed by the MARMP Professional Advisory Council on Cancer has as its objective the establishment of needed new capabilities and the more effective utilization of existing capabilities and resources for the overall improvement of the patient with cancer. This objective will be sought through the mechanism of cooperative relationships, subregional organization, demonstration and organized continuing education programs.

In a previous meeting, the Regional Advisory Group had approved a "Cooperative Stroke Program" developed by the Professional Advisory Council on Stroke. The Heart Disease Program is in process. These disease-oriented plans are expanded components of the MARMP Program Plan, developed and approved previously by the Regional Advisory Group, which provides the overall goals and objectives of the Michigan Regional Medical Program.

Irwin Schatz, M.D., was appointed by Wayne State University as its representative to the Regional Advisory Group in place of Ernest Gardner, M.D., who resigned.

At the May 23 meeting, Doctor Schatz was named to fill Doctor Gardner's vacancy on the board of directors, a nine-member body elected by the Regional Advisory Group, while the board of directors elected John Peirce, M.D., to the position of vice president to fill Doctor Gardner's unexpired term.



Results Being Tabulated on Study of Physician's Post-Grad Education Needs

Officials in charge of the study of Michigan physicians' post-graduate educational needs, sponsored by the Michigan Association for Regional Medical Programs, hope to analyze the data collected by the survey by September or October.

Tabulation of the results began late in June after two weeks of phone calls to the remaining doctors among the 1,600 surveyed who had not mailed

back completed questionnaires.

As of early June, 73 percent of the physicians questioned had returned their surveys, according to Neal A. Vanselow, M.D., Ann Arbor, co-director of the study, and associate professor of internal medicine and postgraduate medicine at the University of Michigan. He was predicting then that 80 percent of the surveys would be returned.

Reports on the results of the survey, which is attempting to determine if and how Michigan physicians would like to have their postgraduate education improved, will be made available as soon as possible to appropriate MSMS com-

mittees and The Council, according to Doctor Vanselow.

The survey was first suggested at a meeting in 1968 of the MSMS Committee on Postgraduate Education, chaired by Harry A. Towsley, M.D., Ann Arbor. The idea was then taken by committee members to the Center of Research for the Utilization of Scientific Knowledge (CRUSK) at U. of M., where the questionnaire was drawn up and the study planned.

Program director of the study is Floyd C. Mann, Ph.D., CRUSK director,

while Anthony Riley is the other co-director with Doctor Vanselow.

Wayne Medical Alumni Honored at Graduation

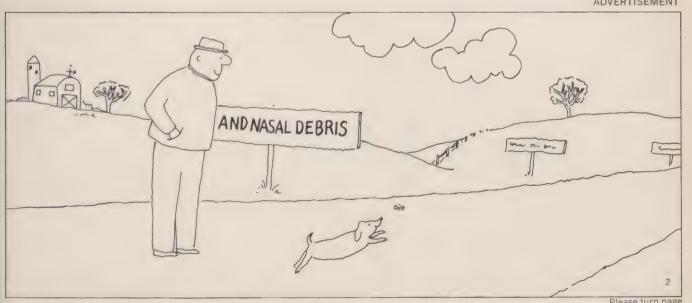
Distinguished service awards from the Wayne State University School of Medicine were presented at spring graduation recently to Peter J. Talso, M.D., Chicago, Class of 1945, and E. Clinton Texter, Jr., M.D., Temple, Tex., Class of 1946.

Doctor Talso is chairman of the Department of Medicine at Loyola University, Chicago, and Doctor Texter is chairman of the Department of Physiology at the Scott and White Clinic in Temple, Tex.

DOCTOR BRENNAN FIRST ADVISORY GROUP CHAIRMAN FOR MARMP

Michael J. Brennan, M.D., professor of medicine at Wayne State University, has been elected the first chairman of the Regional Advisory Group, the top decision-making unit of the Michigan Association for Regional Medical Programs. Doctor Brennan presides over the meetings of the group, which is headed by President Donald Marshall, M.D., Kalamazoo.

ADVERTISEMENT



Health Department Attracts Manpower With "Sounds of Michigan's Surf"

In addition to the ongoing efforts of the Michigan Health Council to obtain more doctors for Michigan, the Michigan Department of Public Health has an attractive blue folder that explains "public health opportunities in Michigan."

The state folder, in part reads:

"Michigan has been described as The Health Capital of the World because of its achievements, resources and human talents. The health service industry is rapidly becoming the largest employer in Michigan. Along with this growth will be a doubling of opportunities during the next ten years.

"The rustle of leaves, the sounds of the surf, the excitement of people and cities on the move are all part of Michigan. Michigan works hard and plays hard and has learned to do both well. We have more than 3,000 miles of Great Lakes shoreline, more than 11,000 inland lakes, 19 million acres of forest with 18,000 campsites, more than 80 winter sports centers and 1,200 miles of toll-free divided highways to help you enjoy them.

"Michigan is livability – good living with its combination of year around recreation, fine educational institutions, cultural advantages and public services.

"Most of all, Michigan is people - warm, friendly people. Three out of every four householders own their homes and are committed to better communities, schools, parks and good government.

"Michigan's citizens support their schools, hospitals and community cultural activities. Good citizens, good neighbors, challenging work and happy, healthful living make up the good life in Michigan.'

MSPA Elects President-Elect

The Michigan State Pharmaceutical Association has elected Robert M. Lambert of Allen Park president-elect, to serve behind current President Lynn H. Cook, R.Ph., of Flint. Mr. Cook took office at the association's annual meeting June 22-25.

CHP AGENCIES INVENTORY UPDATED

A revised and updated edition of the report "Inventory of Community Health Planning Agencies," has been issued by the Health Insurance Council. Copies of the report are available at \$2 each through the HIC at 750 Third Ave., New York, N.Y. 10017.



Report Scheduled On Two-Year Rheumatic Study

"Are rheumatic fever and rheumatic heart disease significant public health problems in Michigan at this time?"

"Are existing facilties and services adequate to meet current needs?"



Doctor Parker

Answers to these questions will be offered Michigan physicians and public health officials at a reporting session of the two year long Michigan Rheumatic Fever Study, 3 p.m. to 5 p.m., Wednesday, July 30, in the auditorium of the University of Michigan School of Public Health, Observatory and Washington Heights Streets, in Ann Arbor.

The study, financed by the Michigan Heart Association, was sponsored by the School of Public Health, and aided by the Michigan Department of Public Health.

Walter G. Parker, M.D., M.P.H., principal investigator, will present the results of a series of studies in five fields: incidence of RF and RHD, primary prevention, secondary prevention, facilities and services available, and Michigan research. He also has studied corrective surgery for RHD as well as hospital admissions.

The study was guided by a Technical Advisory Committee chaired by John Isbister, M.D., Chairman, Bureau of Community Health, Michigan State Department of Public Health.

NON-PRESCRIPTION DRUGS OUTLINED IN NEW HANDBOOK

The American Pharmaceutical Association offers its new Handbook of Non-Prescription Drugs to interested physicians.

The new hard-cover Handbook, contains 160 pages with updated text, tables of products, new formulas and both a product and a manufacturers index.

Orders should be sent to Order Desk, APhA, 2215 Constitution Avenue N. W., Washington, D.C. 20037. Orders under \$10 must be accompanied by payment.

RAT BITES RECORDED

There were 123 reported rat bites in Detroit in 1947. Last year there were only 38, compared to 52 reported in 1967.

The Detroit Health Department's Rodent Control Division went to 252,489 premises last year and spread poison to kill rats, and recommended further controls.

Michigan Births Still Falling

The latest figures available from the Center for Health Statistics of the Michigan Department of Public Health show a continued drop in births registered in Michigan.

The total of registered births in 1968, as of September, was 4,197 fewer than the number recorded through the same month in 1967. In contrast, there were 3,189 fewer registered births throughout all of 1967 compared with 1966.

As of September, 1968, cumulative birth registrations for the year totaled 113,185. By September of 1967 there had been 117,382 births registered. The total of all registered births in 1966 was 164,826 and in 1967 a total of 161,637 births were registered.

100/300 coverage.





AMA SURVEYS RURAL PHYSICIANS

The American Medical Association's Council on Rural Health surveyed a random sample of 2,468 physicians practicing in non-metropolitan areas of the U.S. in 1967 through a questionnaire entitled, "Medical Practice in Small and Large Communities."

The questionnaire, which covered 71 items, was divided into three categories: 1) background material; 2) medical practice organizations; and 3) factors associated with practice and community.

Among the major findings were the following:

a) "Nearly one-half (49%) of the physicians reared in towns under 2,500 were practicing in a similarly sized town, while the same percentage held true for physicians practicing in non-metropolitan cities of 25,000 or more and who were reared in cities of this size. The results would seen to indicate that the best chance of securing physicians for the smaller-sized communities is to have more young men with such a background enter the study of medicine.

b) "In regard to finding the location to practice, the hometown preference or suggestions of friends were most often listed, followed by nearby place of internship, as well as assistance of state and AMA Physician

Placement services.

c) "Limited accessibility to continuing medical education programs and lack of opportunities for professional growth were of concern to the respondents, and, in particular, to those practicing in the isolated rural counties.

d) "Physicians who liked rural practice and living did so because of the feeling that rural people were friendly and dependable, thus resulting in close, personal ties with the people; because they liked to be near the open country for recreation; because there was less traffic and confusion and a slower pace; and because relationships with their patients were pleasant.

e) "They indicated reasons for dissatisfaction with their present location centered around community limitations such as lack of social and cultural activities; shortage of physicians and other health personnel; lack of educational facilities; and inadequate living conditions."

To obtain a complimentary copy of the complete summary listing the 14 major findings of the comprehensive study, please direct your request to the AMA Council on Rural Health, 535 North Dearborn Street, Chicago, Illinois 60610.

MD Placement Notice

- —Looking for a smaller town that needs and wants a physician?
- —Do you need an associate or assistant in your practice?
- —Are there towns in your area in need of additional physicians?
- —If your answer is YES to any of the above questions, contact

Michigan Health Council John A. Doherty, Executive Secretary 712 Abbott Rd., P.O. Box 431 East Lansing (Phone: 337-1615) (No charge for this service)

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phenylephrine HCI, 15 mg·; phenylpropanolamine HCI, 15 mg·
UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Changes in MSMS Section Leaders

The following MSMS Sections have had changes in leadership since the last listing published in the April issue of *Michigan Medicine*. These are the correct officers:

SECTION ON ANESTHESIOLOGY

Chairman: John Coleman, M.D., 1100 6th St., Traverse City 49684 Secretary: Ralph E. Bauer, M.D., Henry Ford Hospital, Detroit 48202

SECTION ON NEUROLOGY

Chairman: Ernst A. Rodin, M.D., 951 E. Lafayette, Detroit 48207 Secretary: Joseph L. Whelen, M.D., 23 W. Adams Ave., Detroit 48226

SECTION ON NEUROLOGICAL SURGERY (MICHIGAN ASSOCIATION OF NEUROLOGICAL SURGEONS)

Chairman: Frederick R. Latimer, M.D., 1005 Mutual Building, 28 W. Adams, Detroit 48226

Secretary: Philip J. Huber, M.D., 1724 Bassett, Royal Oak 48067

SECTION ON OPHTHALMOLOGY

Chairman: Ray A. Pinkham, M.D., 611 Whitcomb St., Kalamazoo 49001 Secretary: Conrad S. Heyner, M.D., 15901 W. Nine Mile Road, Southfield 48075

SECTION ON PATHOLOGY (MICHIGAN SOCIETY OF PATHOLOGISTS)

Chairman: Leo W. Walker, M.D., St. Lawrence Hospital, Lansing 48914 Secretary: Frank N. Ritter, M.D., 2675 Englave Drive, Ann Arbor 48103

SECTION ON PLASTIC SURGERY

Chairman: John H. Packer, M.D., 2909 E. Grand River, Lansing 48912 (Deceased) Vice Chairman: Joseph H. Naud, M.D., 412 Dav. Whitney Bldg., Detroit 48226 Secretary: Robert M. O'Neal, M.D., 221 N. Ingalls, Ann Arbor 48104

SECTION ON PROCTOLOGY

Acting Chairman: George Kinsley, M.D., 909 Woodward Ave., Pontiac 48053 Secretary: H. J. Hazledine, M.D., 4685 Lakeshore Road, Port Huron 48060

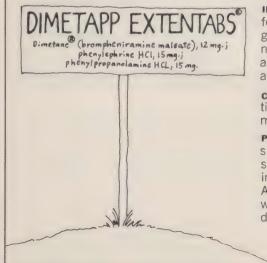
SECTION ON THORACIC SURGERY (MICHIGAN SOCIETY OF THORACIC SURGEONS)

Chairman: Conrad R. Lam, M.D., Henry Ford Hospital, Detroit 48202 Secretary: Raymond J. Barrett, M.D., 18280 Fairfield, Detroit 48221

SECTION ON UROLOGY (DETROIT BRANCH, AMERICAN UROLOGICAL SOCIETY)

Chairman: James M. Pierce, Jr., M.D., Wayne State University, Detroit 48207 Secretary: George R. Sewell, Jr., M.D., 411 W. 10 Mile Road, Pleasant Ridge

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INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, hayfever and conjunctivitis.

CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

side effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

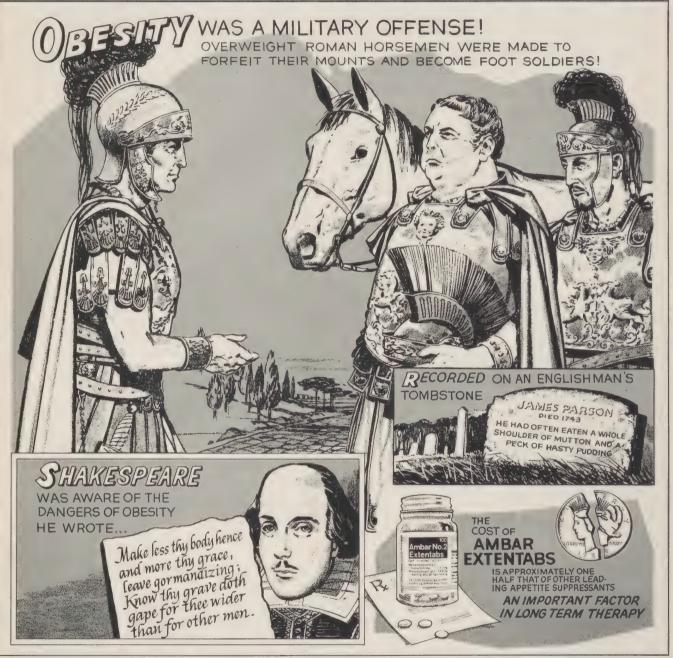
DOSAGE: 1 Extentab morning and evening.

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barbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®-methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

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BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. Contraindications: Hypersensitivity to barbiturates or sympathomimetics; patients with advanced

renal or hepatic disease. Precautions: Administer with caution in the presence of cardiovascular disease or hypertension. Side Effects: Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further A. H. ROBINS COMPANY, A-H-ROBINS RICHMOND, VA. 23220 details.

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Good Medicine. **Good Politics** Go Together

BY DONATO F. SARAPO, M.D. CHAIRMAN, MD-PAC

All doctors are taught to seek the goal of patient care and to bring about the good health of the individual patient. This necessitates that doctors concern themselves with the internal physiological environment of the patient and that they, the doctors, also be aware of the influence external factors have upon the patient's health.

When the physician understands the interaction of these factors, he must personally communicate his knowledge to the patient so that the ultimate well-being of the patient can be brought about. This must be done in a human one-to-one communication between patient and doctor.

People as human beings need human awareness and human consideration. When the patient is treated as a human being and not merely as an organism with a particular disease entity, then often the disease will more readily be controlled and the patient's human well-being will be brought about.

Patients need good professional medical help to protect their health against all the environmental factors which may threaten their state of well-being. In our technological society the patient faces more than the threats of bacteria and viruses. The patients' health is now threatened by chemical contaminants in the air, in water, in food, and in all aspects of community life. These



EDITORIAL

external risks create internal problems and often human psychological problems which come under the care of the private physician.

Third Party Involved

Since all factors of the external environment affect the health of all people in the United States, a third party has become involved. This third party is government collectively representing the citizens of the United States. The government is not only involved in health because citizens are involved, but also because citizens living collectively in cities, towns, etc., actually create many of their own health problems. Formerly government involvement was limited to impersonal aspects of health in the form of public health. This term "public health" is becoming so broad as to now encompass personal as well as impersonal involvement in the citizens' health problems.

Today we are witnessing a new attitude of legislators and administrators toward the health problems of the state and nation. They may have the well-being of all citizens at heart but nonmedically trained legislators and governmental administrators need professional medical advice to properly accomplish their objectives.

Medical orientation toward medical problems is necessary in order that good medical legislation be enacted and executed. The lawmakers need the doctors' help to properly orient their attitudes toward good patient care. Often the legislator's only contact with medicine is as a patient, and he must be helped to view medical problems from the objective professional point of view as well.

Legislators are now making decisions which are not purely economic. They decide on the medical facilities available to care for patients, on the types of facilities, on the training programs available for personnel, on the segments of the population where medical resources should be applied, on the types of care to be rendered, and on the research areas where more professional attention should be directed. Even what drugs should or should not be given for particular disease entities has been indirectly suggested by governmental agencies.

We Must Communicate

As physicians trying to accomplish the objective of good patient care and to bring about the good health of the patient, we must now communicate directly with government and the people of government.

This can be done by Michigan doctors through MD-PAC. Michigan Doctors Political Action Committee can help the doctor to reach and actively support men in the Michigan House and Senate and in the United States Congress. They will be legislators who will understand the multi-faceted medical needs of your patients, and who will listen to sincere medical professional advice on how the

(More Editorials, Page 756)

in the treatment of

3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.

Alleviation of fatigue noted Case histories on 4 patients

cannot be disputed.

Effectiveness confirmed by another double blind study* Forty cases reported. Cites synamics

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Each white tablet contains: Methyl Testosterone ... 2.5 mg. Thyroid Ext. (1/4 gr.) ...15 mg. Ascorbic Acid (Vit. C) .250 mg. Thiamine HCL25 mg. Thiamine HCL 25 mg.
Glutamic Acid 100 mg.
Pyridoxine HCL 5 mg.
Niacinamide 75 mg.
Calcium Pantothenate 10 mg.
Vitamin B-12 2.5 mcg.
Riboflavin 5 mg. Riboflavin

Dose: 2 tablet twice daily. Available: Bottles of 60, 500,

7. Although psychotherapy still needed, role of chemotherapy also available with ESTROGEN

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Each Tablet Contains: Each Tablet Contains:
Methyl Testosterone 2.5 mg.
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Thyroid Ext. (1/6 gr.) 10 mg.
Thiamine Hydrochloride 10 mg.
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NO mg.

NOIGATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Strogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis: 005E: One tablet ti.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIDE EFFECTS: In the female accessive dosage may produce of medication. SIDE EFFECTS: In the female, excessive dosage may produce virilizing effects of most androgens-hoarseness, hirsuism, enlarged ciliotis. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterome per month. CONTRA-INDICATIONS: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs. or mammary clarks used in latent mangnancy or tive organs or mammary glands

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Become a member of MD-PAC now and help your patients by supporting good legislators. Send your membership (\$25.00) to: MD-PAC, Box 169, East Lansing, Michigan.

Let Freedom Ring

To commemorate this most patriotic of months, MICHIGAN MEDICINE publishes, with permission of the author, the following excerpt of an article first printed in the Bulletin of the Oakland County Medical Society.

BY ROBERT P. RICHARDSON, M.D. HUNTINGTON WOODS

What is it — this freedom? Is it only that we may, without fear of disapprobation, wave the flag, march in parades, give utterance to anything we choose (excepting slander), worship as we choose, vote for whom we choose, live where we choose, work or not work as we see fit, be industrious or lazy, love or hate, walk or run, pick our own physician, dentist or milkman?

No — it is much more than this. It is an awesome thing — this freedom! For with it comes responsibility — the charge invested in us to use this free will for the good of mankind and not merely as license for our own selfish desires and ambitions, to love only that which is worthy and to hate that which is unjust. It does not mean that we can go scot-free or undisciplined.

There are many connotations to free will — the most important being the tolerance, the sympathy and the understanding that leads to friendship not only between two people or ten people, but all peoples everywhere.

This freedom endows us with incalculable blessings from the exchange of ideas that work for progress in all fields of endeavour — our own medical field, science, education, art, etc.

It is because of this freedom that this country (always a haven of refuge from religious tyranny and political persecution) abounds in opportunities of every description — ours for the taking — and ours to cherish and grow on and to share so that we will not give the lie to that lovely lady on our shore who says — "give me your tired, your poor, your huddled masses yearning to be free. . ."

Medicare: Boon to the Aged Or Cruel Hoax?

The following article, which first appeared in The Bulletin of The Oakland County Medical Society, is reprinted with permission of the author.

BY JOEL I. HAMBURGER, M.D. SOUTHFIELD

After one and one-half years' experience, there are definite impressions forming about the effectiveness of Medicare in alleviating the financial burden of ill health for the aged. Prior to Medicare, the elderly either provided themselves with insurance, paid cash for their medical expenses or were forced to accept the status of charity patients. As much as anything else, it was concern for the loss of dignity which the poor aged were forced to accept as the price for medical care, which motivated the Medicare legislation. To avoid any type of "means test" was a cardinal aim of Medicare. Medicare was to be a right for all the aged.

Let us examine how well Medicare has served to assist the aged population. To obtain benefits under Medicare, the elderly must pay the first \$50.00, 20 per cent of the balance, and sacrifice \$4.00 per month from their Social Security payments. That is, he must pay \$98.00 per year before he gets any benefits; and, then, only 80 per cent of the balance of his expenses are covered. If he elects to purchase additional Blue Cross-Blue Shield coverage, this will cost him about \$70.00 a year, and he still must pay the first \$50.00 and 20 per cent of outpatient expenses. These figures can be doubled for a couple. Hence, he has paid about \$170.00 (\$340.00 per couple) plus 20 per cent of his outpatient expenses. What more overt "means test" could have been envisioned than the obvious financial barrier which effectively prevents the poor elderly from rising from charity status? All that Medicare has done for the elderly poor is to provide Federal funds (taken from today's working population) to pay for local charity clinics, which had traditionally been supported by local funds. In addition, the poor must pay \$4.00 per month to contribute to the upkeep of these clinics.

What has Medicare done for the more affluent aged? Before Medicare, they were able to obtain Blue Cross-Blue Shield which paid for hospital expenses, generally in full, and a considerable portion of outpatient expenses. What was covered was clear and what had to be paid was clear. With Medicare, the elderly are no longer able to

obtain the same type of Blue Cross-Blue Shield coverage. Now, the patient must pay his \$98.00 per year, 20 per cent of his outpatient expenses, and the balance of his doctor's bills, and wait to collect his reimbursement. This wait can be months, and in some cases, years. He must bear the responsibility for obtaining receipts and, in many instances, preparing the paper work. Otherwise, his doctor must do if for him and bear the added clerical expense. What used to be a relatively simple procedure has been made vastly more complex, and most of the elderly do not see what they have gained. To be sure, isolated examples of benefits from Medicare can be cited; but the overall picture has been bleak.

What about cost to the government? Staggering is the only appropriate term. Yet, what has been purchased for all this Federal outlay — other than administrative costs?

We were told that doctors have been profiteering. Yet, few doctors can afford many Medicare patients. The extra burden of clerical expense, the delay in receiving payment, plus all the explaining of what is and what is not covered is a taxing load. This is a continuing burden as each year brings in a new crop of eligible elderly patients. Certainly, doctors have increased their fees since Medicare came in; but physicians should not be made to accept the onus for the failings of Medicare. Doctors did not ask for the increase in Social Security and other taxes which have increased their cost in providing medical care. Doctors could not refuse to give their employees the needed increased salaries to meet higher costs of living. Doctors did not vote for higher rents they must pay for their offices and for higher prices they must pay for all supplies and materials. Nor did doctors vote for state income taxes and the Federal surcharge. But doctors must pay all of these increased costs — and the money ultimately comes only from the patients.

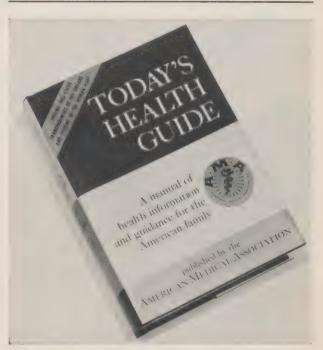
Hospitals have been accused of inefficiency and waste; and, perhaps, there is some basis for this, but hospitals have been barely able to exist within the Medicare formula. Money for expansion or replacement of facilities and/or equipment has dried up. Money to meet current expenses must be obtained by bank loans, because of delinquent Medicare payments. Hospitals, too, must meet the demands of rising costs. Nurses, interns and other hospital employees will no longer work for slave wages. Abut three-quarters of hospital costs are salaries and most hospitals have two to three employees per patient; hence, it is obvious that costs must rise beyond \$50.00 to \$60.00 per day for help alone, and what about food, medicines and other necessities for patient care?

In summary, the failures of Medicare are not the doctor's fault or the hospital's fault. They are the result of an incredibly poorly conceived plan and the inevitable participation of medical costs in the general inflationary spiral. There doesn't seem to be much that can be done about inflation; but it is time to recognize that Medicare, as we know it today, should be scrapped in toto and a new plan substituted. It should be a simple and realistic plan which promises only what can be delivered. For example, the government might pay for the cost of Blue Cross-Blue Shield contracts, similar to the old M-75 contract, which would provide the cost of ward coverage in the hospital, as well as an additional coverage of a fixed percentage of physician's fees. This percentage could be determined on the basis of the available revenue. A simple contract of this type would eliminate millions of dollars of administrative costs which have been created by virtue of the complex contract now in existence, with its multiple deductible features, and inclusions and exclusions. Furthermore, with such a simple plan, everyone would know what is covered and what is not.

When to Talk?

"Often we spend too much time trying to decide how to communicate, when we need to evaluate if we have anything important to talk about or to say."

Prof. Ruth Useem MSU College of Education



County medical societies are purchasing copies of the AMA Today's Health Guide book for presentation to libraries, schools and other community outlets. The book, which physicians might like to have available in their waiting rooms, contains 640 pages of general advice. Copies are available at cost from the AMA at \$5.95. More than 20,000 diseases, illnesses, medical conditions and subjects are thoroughly covered, with more than 300 illustrations.



COMMITTEE CALENDAR

Most MSMS committees suspend the bulk of their meetings over the summer months. The following is a list, however, of the June committee meetings and those scheduled for the future:

> Wednesday, June 4 MSMS Headquarters, East Lansing Chairman: Donato F. Sarapo, M.D., Adrian Friday, June 6 Committee on Occupational Health Sheraton Motor Inn, Flint Chairman: William Jend, Jr., M.D., Detroit Wednesday, June 11 Committee on Hospital Relations MSMS Headquarters, East Lansing Chairman: A. C. Stander, M.D., Saginaw Wednesday, June 11 Committee on Financial Structure of MSMS MSMS Headquarters, East Lansing Chairman: C. W. Oakes, Jr., M.D., Harbor Beach Wednesday, June 18 Committee on Governmental Medical Care Programs MSMS Headquarters, East Lansing Chairman: R. E. Rice, M.D., Greenville Wednesday, June 18 Board of Managers Oakland County Medical Society, Birmingham Chairman: John R. Ylvisaker, M.D., Pontiac Wednesday, Oct. 1 MSMS Council Sheraton-Cadillac Hotel, Detroit Chairman: Ross V. Taylor, M.D., Jackson Wednesday, Nov. 5 The Council MSMS Headquarters, East Lansing Chairman: Ross V. Taylor, M.D., Jackson Wednesday, Nov. 12 Committee on Cancer MSMS Headquarters, East Lansing Chairman: M. E. Dodds, M.D., Flint Wednesday, Nov. 12 Michigan Cancer Coordinating Committee MSMS Headquarters, East Lansing Chairman: C. Fred Arnold, Detroit Wednesday, Dec. 17 MSMS Council MSMS Headquarters, East Lansing Chairman: Ross V. Taylor, M.D., Jackson

MARY KITCHEL, M.D. HONORED BY WOMEN

Mary Kitchel, M.D., Grand Haven, was named outstanding woman of the year for 1968-1969 by the Triangle Business and Professional Women's Club of Grand Haven. Fondly called "Dr. Mary" by local residents, Doctor Kitchel has practiced medicine in the area for the past 28 years.

SMOKING PROBLEMS REFERENCE RECOMMENDED

The MSMS Committee on Public Health has recommended the *Proceedings of the National Forum on the Office Management of Smoking Problems* as published in the September 1968 issue of *Diseases of the Chest*, as an excellent reference guide for physicians to use in their office practice.

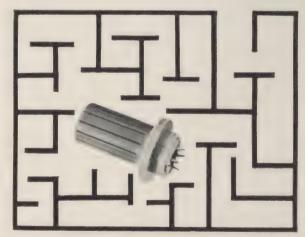
Michigan doctors who are interested may obtain copies of the proceedings by writing to Staff Assistant Helen Schulte, Michigan State Medical Society, 120 W. Saginaw St., East Lansing, 48823.

Committee Approves Mumps Vaccine Guide

The MSMS Committee on Public Health, at a recent meeting, adopted the following statement as its policy on the use of mumps vaccine (subsequently approved by the MSMS Council):

"That consideration be given to immunizing for mumps all susceptible children over one year of age and adults. However, vaccination programs should not be allowed to take priority over other on-going health activities."

The above procedure is recommended to the physicians in the State of Michigan as a general guide.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST

(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

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Dulcolax...so predictable you can almost set patients by it.

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

Dulcolax® bisacodyl





In studies on peripheral vascular disease—a common by-product of the degenerative aging process—considerable attention has focused on the important role of smoking in the progression of the disease. Although it may not be etiologic, smoking is widely recognized as a prominent contributing factor.¹

Skin blood flow—significant factor in PVD. Cutaneous digital vasoconstriction caused by nicotine has been observed both in normal subjects and in patients with peripheral vascular disorders.^{1,2} Among patients with peripheral vascular disease, however, age and the severity of the disease appear to modify the effects of nicotine. For example, in a study of older patients with marked peripheral vascular disease,³ changes induced by smoking were not statistically significant for the group as a whole. This was explained on the basis of decreased skin reactivity. Smoking is not permissible in any stage of the disease, since even "... minimal reduction in blood flow in patients with ischemic limbs may pro-

duce a further reduction in tissue nutrition, and thus may be another case of the proverbial straw on the camel's back."8

In another study of patients with peripheral vascular disease, the investigators stress that decreased skin blood flow during smoking ... is the factor of most importance to the patient with peripheral vascular disease." While such patients may adjust to the discomfort of vascular insufficiency in skeletal muscle, decreased skin blood flow may often lead to severe symptomatology.

More and more physicians have adopted the practice of investigating for peripheral vascular disorder when confronted with a geriatric patient who is a habitual smoker. Once a diagnosis is established, therapeutic measures are directed toward increasing the peripheral circulation and appropriate management of the patient's general medical needs. These include the important safeguards of keeping warm and refraining from smoking. Professional model posed for illustration.

Important in total management of peripheral vascular disease, vascular spasm or chilblains Roniacol Timespan (nicotinyl alcohol tartrate)

for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.

Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual

in onset, rarely causing severe flushing.

Selectivity of action—relaxes the musculature of peripheral blood vessels. High degree of safety—side effects seldom require discontinuation of therapy.

Before prescribing, please consult complete product information, a summary of which follows: Indications: Conditions associated with deficient circulation; e.g., peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients. Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets morning and night.

How Supplied: Timespan Tablets-150 mg nicotinyl alcohol in the form of the tartrate salt, bottles of 50.

References: (1) Roth, G. M.; Shick, R. M., and Secrest, R. R., in James, G., and Rosenthal, T., eds.: *Tobacco and Health*, Springfield, Ill., Charles C Thomas, 1962, pp. 311-322. (2) Entmacher, P. S.: Proc. Med. Sect. Amer. Life Convention 51:149, 1963. (3) Freund, J., and Ward, C.: Ann. New York Acad. Sci. 90:85, 1960. (4) Coffman, J. D., and Javett, S. L.: Circulation 28:932, 1963.





"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet dis-

integration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.







NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

John E. Dwyer, M.D., 425 E. Washington, Ann Arbor 48108

Donald H. Kuiper, M.D., University Hospital, Ann-Arbor 48104

Richard D. Nichols, M.D., (Trans. from Assoc.), Henry Ford Hospital, Dept. of Oto., Detroit 48202

Thompson H. Southwell, M.D., University Hospital, Ann Arbor 48104

Kenneth W. Teich, M.D., (Reinstatement), 1st Nat'l Bank Bldg., Comm. Prof. & Hosp. Act, Ann Arbor 48108

Charles W. Waldron, M.D., St. Joseph Mercy Hosp., Ann Arbor 48104

Walter L. Webb, M.D., (Reinstatement), St. Joseph Mercy Hosp., Ann Arbor 48104

Bruce A. Work, Jr., M.D., L-2019 Women's Hospital, Ann Arbor 48104

E. K. Zsigmond, M.D., University of Mich., Ann Arbor 48104

Anna H. Broecker, M.D., 1840 Wealthy St., SE, Grand Rapids 49506

Almario M. Garaza, M.D., 1521 Gull Road, Kalamazoo 49001

Lawrence E. Grennan, M.D., (Transfer from Associate), Liberty Life Bldg., Muskegon 49443

David H. Gilbert, M.D., 146 Osceola St., Laurium 49913

Anna Novak, M.D., 1706 Helen St., Kalamazoo 49002

Harold J. Reese, M.D., 1002 S. Brown St., Mt. Pleasant 48858

Paul W. Sundin, M.D., (Transfer from Associate), Decatur 49045

William J. Venema, M.D., 517 Pleasant Ave., Kalamazoo 49001

Arno A. Whipple, M.D., (Reinstatement), Rural Station, Moorestown 49651

Frederick M. Adams, M.D., (Reinstatement), 800 S. Adams, Birmingham 48011

Max A. Finton, M.D., P.O. Box 368, Northport 49670

Hildo H. Fiori, M.D., 770 Fisher Bldg., Detroit 48202

Norman H. Harebottle, M.D., (Reinstatement), 1143 W. 12th St., Tempe, Arizona 85281

Lawrence LaGatutta, M.D., 560 Linn Street, Allegan 49010

Ricardo A. Yuzon, M.D., (Reinstatement), 140 Elizabeth Lake Rd., Pontiac 48053

Ruth B. Brackett, M.D., 18136 Mack, Detroit 48224

Gregorio R. Caturay, M.D., Detroit General Hosp., Detroit 48226

Gilbert E. Corrigan, M.D., 400 E. Lafayette, Detroit 48226

Mario Cote, M.D., 25447 Plymouth Rd., Detroit

Christopher Deen, M.D., 1800 Tuxedo, Detroit 48206

H. David Fenske, M.D., 412 Phoenix St., South Haven 49090

Richard P. Horsch, M.D., 32900 Five Mile Rd., Livonia 48154

Arthur H. Johnson, Jr., M.D., (Reinstatement), 429 North St., SW #506, Washington, D.C. 20024

Benjamin J. Kleinstiver, M.D., 517 E. Lake St., Petoskey 49770

Emil W. Lebedovych, M.D., 26490 Westphal Dr., Dearborn Heights 48127

Charles E. Lucas, M.D., Detroit General Hospital, Detroit 48226

Robert A. Mengebier, M.D., Blanchard Road, Petoskey 49770

Sinforoso S. Padilla, Jr., M.D., 5149 St. Jean, Detroit 48213

Harold C. Papson, M.D., 12200 E. Jefferson, Detroit 48215

Ronald D. Peterson, M.D., Ford Motor Co., Dearborn 48121

Kianoosh Radsan, M.D., 15101 Southfield, Allen Park 48101

Charles Berman, M.D., (Reinstatement), 461 West Huron Street, Pontiac 48053

Howard C. Bruckner, M.D., 6814 Parkbelt Drive, Flint 48505

James Clark Moloney, M.D., (Reinstatement Non-Resident membership), Napa State Hospital, Napa, Calif. 94558

James R. Murphy, M.D., 433 Fox Hills Drive, Apt. 1, Bloomfield Hills 48013

Edward Petrovich, M.D., 960 Westview Road, Bloomfield Hills 48013

William C. Swatek, M.D., 900 Woodward Avenue, Pontiac 48053

Mary Grace Warner-Dunlop, M.D., (Associate membership), 1840 Wealthy Street, S.E., Grand Rapids 49506

TESTIMONY OF "NONTREATING" PSYCHIATRIST

In a prosecution for second degree murder in which the defense of insanity was raised, a trial court's exclusion of the records relating to the accused's hospitalization several months before the killing and its refusal to permit a "nontreating" psychiatrist to testify as to the history given him by the accused were improper. However, the errors were not prejudicial to the accused's right to a fair trial, a Michigan appellate court ruled.

The hospital records covered the accused's admission to the emergency room on two occasions, within a period of only a few days, because of her consumption of an unknown amount of phenobar-

bital.

The portion of the record of the first admission that was concerned with her physical condition and her consumption of phenobarbital should have been admitted in evidence. However, the portion concerned with diagnosis was properly excluded. The admission of a physician's unsupported diagnosis, when he is not available for cross-examination, would not be in keeping with sound criminal trial procedure. The accused was not prejudiced by the exclusion of the record of her second hospital admission since the physician who diagnosed her case at that time testified fully as to her condition later in the trial.

The trial court refused to let the psychiatrist testify as to the history given him by the accused when he examined her, on the ground that, since he was not a "treating" psychiatrist, the history would be self-serving and hearsay. The objection that the history is self-serving can be overcome by reliance on the psychiatrist's expertise, experience, and ability in detecting liars, the reviewing court said. However, the error in refusing to permit the psychiatrist to testify as to the history given him by the accused was not prejudicial to her right to a fair trial because the psychiatrist was permitted to state an opinion based upon a hypothetical question composed of facts already elicited from other witnesses. - People of the State of Michigan v. Herrera, 162 N.W.2d 330 (Mich., June 26, 1968).

from Vol. 18, No. 11

Editor's Note: The following articles are quoted from the AMA Citation Newsletter of May 1, 1969, prepared by the AMA Law Department.

PHYSICIAN LIABLE FOR TREATMENT OF FRACTURE

A verdict for a patient in his suit against a physician for his alleged negligence in the treatment of a severe supracondylar fracture and injury to the epiphysis of the patient's left elbow was improperly set aside by a trial court, a Michigan appellate court ruled. On a prior appeal, the state supreme court held that the evidence, which was



LEGAL

substantially the same as that presented on the retrial, was sufficient to raise an issue for the jury as to negligence on the physician's part. The damage award of \$25,000 was not excessive.

The patient suffered the injuries in a fall when he was $4\frac{1}{2}$ years old. The results of the physician's treatment were such that the patient has had to have several corrective operations performed on his elbow.

The patient contended that the physician was negligent in not having referred him to an orthopedist and that such negligence was the proximate cause of the painful and permanent injury to his elbow. On the prior appeal, the supreme court ruled that the evidence presented was sufficient to raise a question for the jury as to the physician's negligence. The evidence presented on the retrial was substantially identical. Since the evidence was sufficient to raise a question for the jury, its finding for the patient could not properly be set aside.

The jury's award of damages was, in view of the patient's injuries, not excessive and thus could not be interfered with. —Morgan v Engles, 164 N.W.2d 702 (Mich., Oct. 23, 1968)

Editor's Note: The Michigan Supreme Court's decision on the prior appeal was reported in THE CITATION, Vol. 9, No. 8, p. 128.

from Vol. 19, No. 2

OPTICIANS ENJOINED FROM FITTING CONTACT LENSES

An injunction prohibiting several opticians from engaging in the unlawful practice of optometry by examining the eyes of persons for contact lenses and fitting and inserting such lenses was affirmed by the Michigan Supreme Court. The acts constituted a public nuisance, the court decided. Therefore, the fact that the optometry statute provided a criminal penalty for the unlicensed practice of optometry did not make the criminal penalty the sole remedy or bar the court from issuing an injunction.

The opticians did the contact lens work under arrangements with ophthalmologists who determined the refractive index of the patients. In measuring the patients' eyes, the opticians used a

keratometer or an ophthalmometer.

The statutory definition of the practice of optometry includes the examination of the eye for contact lenses and the fitting or insertion of the lenses to the eye. The statute provides that the unlawful practice of optometry is a misdemeanor, punishable by fine or imprisonment, or both.

The trend of modern authority is that a court of equity may enjoin the unlicensed practice of a profession. At common law, acts in violation of law constitute a public nuisance. Harm to the public is presumed to result from the violation of a statute designed to protect public health, safety, and welfare. The Attorney General, acting on behalf of the people, is a proper party to bring an action to abate a public nuisance or restrain acts constituting a public nuisance. The existence of a criminal or other penalty for the practice of a profession without a license will not oust an equity court from jurisdiction. —Attorney General ex rel. Michigan Board of Optometry v Peterson, 164 N.W.2d 43 (Mich., Feb. 3, 1969)

from Vol. 19, No. 2

TESTIMONY BY NONTREATING PHYSICIAN

In a woman's suit for injuries sustained in an automobile accident, a trial court abused its discretion in refusing to permit her to recall an orthopedist who had not treated her to testify on the basis of X-rays that he had ordered taken, a Michigan appellate court ruled. The striking of the testimony of an ophthalmologist who had not treated her was also improper.

The woman's injuries consisted of damage to the lower back and left hip area, as well as an injury to her neck and the right side of her head. There was also some damage to the right eye.

The woman elected to invoke the physicianpatient privilege, thus barring the treating physicians from testifying. She sought to support her claim by the testimony of an orthopedist and an ophthalmologist, neither of whom had even examined her.

The orthopedist was asked a hypothetical question as to the probable connection between the injuries received in the accident and the woman's present condition. His answer that there was such a probable connection was based in part on X-rays taken by the treating physician and in part on X-rays that he himself had ordered to be taken.

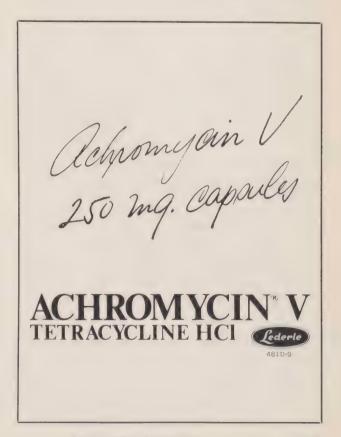
The testimony was stricken because the X-rays taken by the treating physician were necessary diagnostic tools and thus within the physician-patient privilege.

After resting her case, but before the allegedly negligent driver had entered upon his proofs, the woman asked leave to recall the orthopedist and examine him on the basis of the X-rays which he had ordered taken. The request was denied.

A reopening of the proofs is a matter within the trial court's discretion. The only way in which the driver would have been prejudiced if the request had been granted would have been that the case would have to have been continued to later the same day to accommodate the orthopedist's schedule. He was not a new witness and his new testimony would have been based on exhibits already in evidence. There would have been no surprise or undue hardship to the driver. On the other hand, the disallowance of the request deprived the woman of evidence of a causal connection between her injuries and her present condition, an essential element of her case.

The ophthalmologist testified that the herpetic keratitis from which the woman was suffering could have been caused by the eye injury. The evidence was stricken because he could not say with reasonable medical certainty that it had been caused by the injury. The physician need not have testified in terms of reasonable medical certainty, the court said. A physician's evidence that a condition could be caused by an injury is admissible. —Knoper v Burton, 163 N.W.2d 453 (Mich., Aug. 26, 1968)

from Vol. 19, No. 2



Editor's Note: the following articles are quoted from the AMA Citation Newsletter of May 15, 1969, prepared by the AMA Law Department.

CHIROPRACTIC SERVICES ARE NOT MEDICAL SERVICES

A medical care corporation was not required to reimburse chiropractors for services rendered to its subscribers, the Attorney General of Michigan ruled in a recent opinion. Chiropractors are not doctors of medicine within the meaning of the statute providing for the organization of nonprofit medical care corporations.

The statute provides that a medical care corporation shall not furnish medical care otherwise than through doctors of medicine licensed under the medical practice act, or podiatrists licensed under the podiatry practice act. The statute makes no mention of the furnishing of care by chiropractors.

Chiropractors were originally licensed to practice under the medical practice act, but were prohibited from using the title of "doctor." They are now licensed under the chiropractic practice act.

In view of the plain wording of the statute relating to medical care corporations, chiropractors are not entitled to reimbursement for services to a corporation's subscriber, unless they are also licensed under the medical practice act.

An informal opinion letter issued in 1941, in which it was stated that it would not be objectionable for a medical care corporation to reimburse a chiropractor for services furnished to a subscriber in an emergency could not be considered authorization for the corporation's reimbursement of a chiropractor for services furnished to a subscriber in a non-emergency situation. —Opinion of Michigan Attorney General, No. 4640 (Mich., Jan. 13, 1969)

from Vol. 19, No. 3

BODIES FOR TRANSPLANT AND RESEARCH PURPOSES

The questions of the availability of freshly dead bodies for transplants and for medical research and the possible civil and criminal liability, under the law of Michigan, in connection therewith were discussed in a bar journal article.

Unclaimed bodies or donated bodies could be used in legitimate scientific research with slight risk of adverse legal consequences so long as the statutory requirements and the terms of the gift were complied with. However, those sources would not be likely to yield a substantial number of freshly dead bodies. The statutes require that unclaimed bodies be held for 30 days and that they be embalmed. Under the anatomical gift act, the donor's survivors must be given an opportunity

to hold a funeral before the body is delivered to the donee.

Michigan law is not well defined as to the use of "other" bodies, those donated by the survivors, for scientific purposes. However, in view of existing law and the social acceptance of scientific medical research, reasonable research conducted under appropriate scientific conditions and with the survivor's informed consent appeared to have only a slight potential for adverse legal consequences.

The question was raised as to whether a legislature could authorize the use of a dead body without consent of any kind or, as such a proposal has been stated — total respect for the living, complete disregard for the dead. —Research on Body Transplants, 48 Michigan State Bar Journal No. 3, p. 11 (March, 1969)

from Vol. 19, No. 3

SUICIDE PREVENTION CENTER HANDLES 250 CALLS PER MONTH

Over 250 calls per month from suicidal persons have been effectively dealt with by the Suicide Prevention Center of Detroit Psychiatric Institute since the center's opening Nov. 8, announces the director, Bruce L. Danto, M.D.

Approximately 70 volunteers have been trained to handle telephone screening and intervention for such calls, continues Doctor Danto.



In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

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MSMS Members In The News

JACK HASSBERGER, M.D., BIRMINGHAM took the part of the girl's father in the Birmingham Village Players recent production of "The Fantasticks." Doctor Hassberger, a practicing pediatrician, joined the Players in 1929 and has directed, acted and been president of the Players.

TWO MSMS MEMBERS.

Gerald Fine, M.D., and Conrad R. Lam, M.D., both of Detroit, are among the authors contributing to a comprehensive new publication, the third edition of *Pathology of the Heart and Blood Vessels*, published recently by the Charles C. Thomas Co. of Springfield, Ill. Doctor Fine is with the Department of Pathology and Doctor Lam, the Division of Thoracic Surgery at Henry Ford Hospital.

WILLIAM J. MATTSON, M.D., ANN ARBOR, received the Fredrick A. Coller Award of the Michigan Chapter of the American College of Surgeons at the chapter's recent awards night banquet. Doctor Mattson, senior resident in general surgery at University Hospital in Ann Arbor, took first place in a competition among surgery residents for the award. He won with a paper on amino acids in coma.

L. G. ROWLEY, M.D., DRAYTON PLAINS, and Mrs. Rowley are making their home in Phoenix, Ariz., following his retirement this spring. Before their departure from Michigan, Doctor Rowley was guest of honor at a retirement dinner given by the staff of the Oakland County Sanitarium, where he was chief of staff since 1966.

ANDREW D. HUNT, JR., M.D., EAST LANSING,

dean of the Michigan State University College of Human Medicine, discussed "Nursing's Role on the Health Team" at the recent Michigan Nurses Association Spring Conference in East Lansing.

L. J. GEERLINGS, M.D., NEWAYGO,
was recently feted on his retirement as medical
director of the Newaygo Medical Care Facility.
The staff of the facility held a dinner in his
honor and presented him with a plaque inscribed, "We will long remember your devotion
and efforts to raise the standard of patient care."
Doctor Geerlings is a past president of the
Newaygo County Medical Society.

BERNARD PATMOS, M.D., ADRIAN,

and Mrs. Patmos were recently named the first husband-wife team recipients of the Adrian Chamber of Commerce Maple Award. They were recognized for their outstanding community service and significant contributions to Adrian and Lenawee County. Doctor Patmos has served four terms as chief of staff of the Bixby Hospital in Adrian and is also active in the Boy Scout movement, the YMCA, the University of Michigan Scholarship Committee, the Rotary Club and the Lenawee Selective Service Committee.

JACQUES S. GOTTLIEB, M.D., DETROIT

has been awarded the Gold Medal for Distinguished Research by the Society of Biological Research for his work on the plasma factor in schizophrenia. The presentation was made at the society's annual convention recently in Miami Beach. Doctor Gottlieb is director of Detroit's Lafayette Clinic and chairman of phychiatry at WSU's School of Medicine.

LOUIS E. HEIDEMAN, M.D., DETROIT

is new acting executive director of Project PRES-CAD (Pre-school, School and Adolescent) to develop comprehensive and continuing services for children in the low income families in specified target areas in Detroit and Wayne County. The project is funded by the Children's Bureau.

WILLIAM F. DWYER, M.D., GRAND BLANC former chief of surgery at McLaren General Hospital in Flint, is new president of the Flint Academy of Surgery. He will lead the group until May, 1970.

ALEXANDER J. WALT, M.D., DETROIT

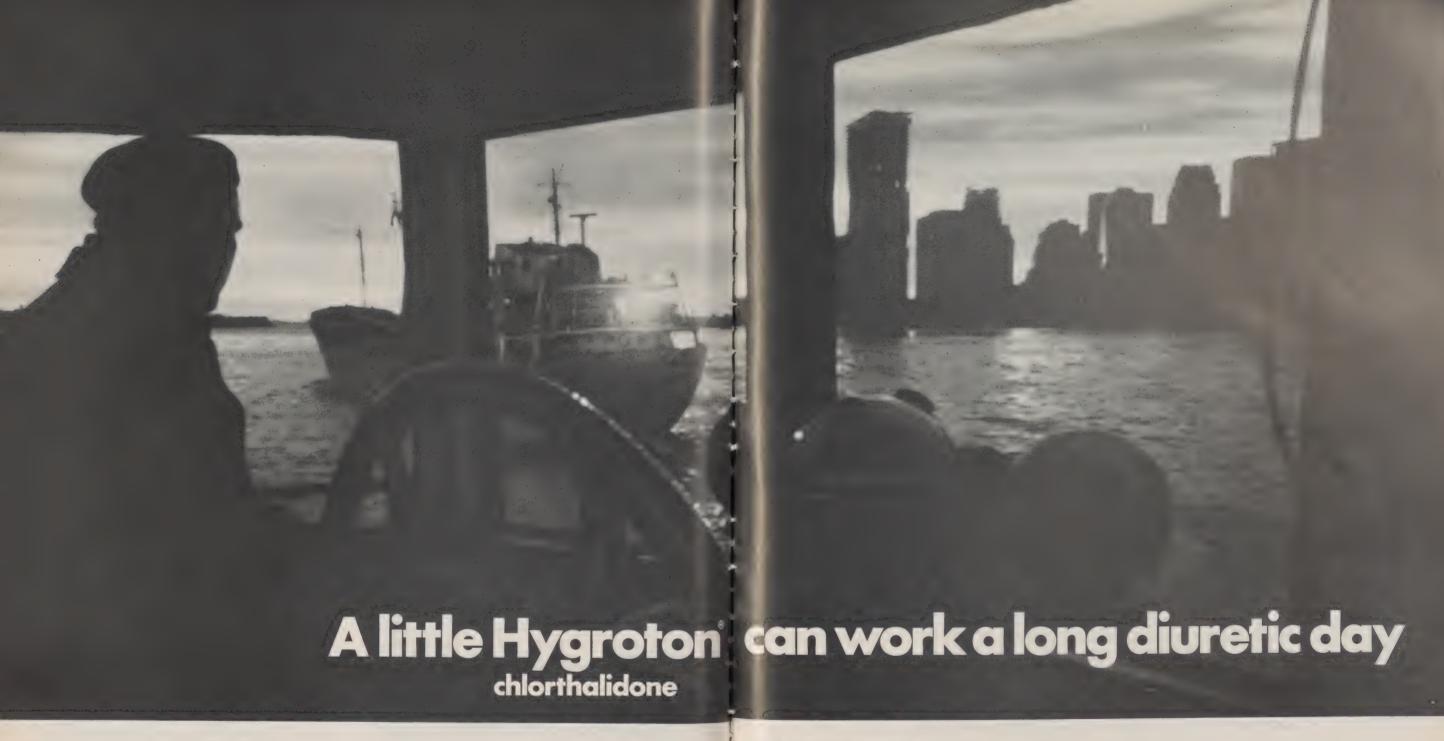
has been appointed a consultant to Review Clinical Cancer Training Grants by the National Institutes of Health. He is associate dean for hospital and clinical affairs and chairman of the Department of Surgery at Wayne State University.

clinical professor of surgery at WSU, has been selected by the British Association of Pediatric Surgery to deliver the Forshall Lecture in Surgery at the University College, Dublin, Ireland.

ROYAL C. HAYDEN, M.D., DETROIT,
Wayne State University Clinical Assistant Professor, has been elected president of the Detroit
Hearing and Speech Center.

PAUL LOWINGER, M.D., DETROIT,

has been elected national chairman of the Medical Committee for Human Rights, the health arm of the civil rights movement, which includes 18 chapters and 6,000 members from the health services.



all the way from one daily tablet to the next to help control edema and hypertension

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chlorthalidone

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Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

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Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If

potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypoten-

sion, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.l. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

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Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Marriage: Acute analysis (real proper feet lands)

Warnings: Acute anaphylaxis (may prove fatal unless promptly con trolled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic

In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions: (Penicillin has significant index of sensitiza-

Adverse Reactions: (Penicillin has significant index of sensitiza-tion): Skin rashes, ranging from maculopapular eruptions to exfolia-tive dermatitis; urticaria; serum sickness-like reactions, including

chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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J. A. Clarke Dorland, M.D. Lapeer

J. A. Clarke Dorland, M.D., Lapeer physician since 1930 and former chief of staff of the Lapeer County General Hospital, died April 9 at the age of 65.

Doctor Dorland, who was graduated from the University of Toronto Medical School, specialized in obstetrics and gynecology and surgery. He was also affiliated with the Lapeer State Home Hospital surgical staff, Hurley and St. Joseph's Hospitals in Flint.

He was a past president, vice president and secretary-treasurer of the Lapeer County Medical Society.

Oscar P. Geib, M.D. Gavlord

Oscar P. Geib, M.D., retired physician who had practiced 50 years in Carson City, died May 9 in Gaylord at the age of 82.

Doctor Geib was a graduate of the Detroit College of Medical Surgery, predecessor of Wayne State University Medical School, which honored him for being one of the longest-practicing physicians it had ever graduated. He was affiliated with Clinton Memorial Hospital in St. Johns.

Lewis F. Brown, M.D. Otsego

Lewis F. Brown, M.D., Otsego, former chief of staff of Pipp Community Hospital in Plainwell, died March 28 at the age of 66.

A specialist in anesthesiology, Doctor Brown was graduated from Wayne State University School of Medicine. He was a member of the American and Michigan Societies of Anesthesiologists and had been Allegan County Medical Society treasurer and delegate to the MSMS House of Delegates.

David B. Hagerman, M.D. Grand Rapids

David B. Hagerman, M.D., for 50 years a Grand Rapids surgeon and physician, died April 11 at the age of 81.

Doctor Hagerman served on the staffs of Butterworth, Blodgett, Ferguson Droste Ferguson, and St. Mary's Hospitals in Grand Rapids and also devoted his services for more than 30 years to Camp Blodgett for underprivileged children. He was a graduate of the University of Michigan School of Medicine.

Doctor Hagerman was a fellow in the American College of Gastroenterology, a life member and past president of the Kent County Medical Society,

IN MEMORIAM

a life member of MSMS and a 50-year member of the AMA.

Harry Y. Kasabach, M.D. Detroit

Harry Y. Kasabach, M.D., Detroit obstetrician and gynecologist, died May 18 at the age of 57.

Doctor Kasabach, who was a former MSMS Council member, was affiliated with Highland Park General, Harper and Hutzel Hospitals. He was graduated from the University of Michigan School of Medicine.

He was a member of both the American College and Michigan Society of Obstetricians and Gynecologists. Doctor Kasabach was a founding member of the American Board of Obstetrics and Gynecology, instructor at Wayne State University School of Nursing and former medical director of the Planned Parenthood League.

John H. Packer, M.D. Lansing

John Harold Packer, M.D., Lansing plastic sur-

geon, died June 5 at the age of 42.

Doctor Packer was a graduate of Wayne State University College of Medicine and was a member of the plastic and reconstructive surgery staffs of Edward W. Sparrow and St. Lawrence Hospitals in Lansing.

He was a candidate member of the American Society of Plastic and Reconstructive Surgery and the American College of Surgeons.

John Robbert, M.D. Battle Creek

John Robbert, M.D., retired Battle Creek orthopedic and industrial surgeon, died April 26 at the

age of 72.

Doctor Robbert, who was a graduate of the University of Cincinnati School of Medicine, had been on the staffs of Leila and Community Hospitals in Battle Creek and had been an industrial physician for 10 years at the Post Division of General Foods Corp. He also served as team physician 12 years for the Lakeview High School athletic groups.

He was a member of the Industrial Medical

Charlotte I. Steinberger, M.D. Farmington

Charlotte I. Steinberger, M.D., Farmington, longtime Detroit-area general practitioner, died late in

April at the age of 52.

Mrs. Steinberger, a native of Hungary, was a graduate of the Wayne College of Medicine and held the position of a staff physician at Wayne State University. She was a member of the American Women's Medical Association and the Blackwell Society.

(Continued on Page 774)

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COUNTY SOCIETIES

WAYNE COUNTY PHYSICIANS RECORD LIABILITY EXPERIENCES

As of mid-May, 1,010 responses had been returned on questionnaires concerning Professional Liability Problems mailed to all 2,900 members of the Wayne State Medical Society.

Only 183 physicians of the 1,010 who had returned their questionnaires indicated that they had one or more malpractice suits filed against them in the past five years.

The questionnaire is sponsored by the Professional Liability Committee of the WCMS. The committee hopes to analyze the data collected to use as a basis of recommendations to MSMS and

the September meeting of the House of Delegates.

IN MEMORIAM/Continued

Joseph L. Toth, M.D. Traverse City

Joseph L. Toth, M.D., Traverse City, a member of the Traverse City State Hospital Staff, died May 6 at the age of 50.

Doctor Toth, born in Hungary, received medical training in Europe and took further study in psychiatry in the United States.

John Charles Tulloch, M.D. Lake Orion

John Charles Tulloch, M.D., Detroit surgeon who made his home in Lake Orion, died April 26 at the age of 69.

Doctor Tulloch, who was affiliated with Harper Hospital and Detroit General Hospital, was a graduate of Syracuse University School of Medicine. He was a member of the American College of Surgeons and the Detroit Surgical Society.

Pre-Schoolers' Screening Tests Sponsored by Lenawee

The Lenawee County Medical Society this spring sponsored vision and hearing screening tests to pre-school children, in conjunction with the Lenawee County Health Department and the Michigan Department of Public Health. The tests are mandatory for all children before entering school, and the medical society, with the other two cosponsors, arranged to set up local clinics throughout the county during the months of April, May and June.

INGHAM COUNTY HONORS YOUTH TALENT WINNERS

Several prizes awarded to winners of the 1969 Central Michigan Youth Talent Exhibit staged in April in Lansing were sponsored by the Ingham County Medical Society. The youngsters who were singled out received their medical society awards at special ceremonies following dinner at an Ingham meeting.

Oakland County Doctors Hear Detroit Controller

Bernard W. Klein, controller of the City of Detroit, discussed "The Urban Crisis" at a recent meeting of the Oakland County Medical Society. Doctors' wives were guests for the special meeting. The Oakland Society members have planned their annual golf outing July 9 at the Indianwood Golf and Country Club in Lake Orion.

Doctor Guttmacher Addresses Kalamazoo Academy

Alan F. Guttmacher, M.D., of New York City, president of Planned Parenthood-World Population, was in Michigan recently and included in his schedule a talk before the Kalamazoo Academy of Medicine. Doctor Guttmacher was the featured speaker at the MSMS-sponsored Maternal and Perinatal Welfare Conference in Flint in March.

GENESEE DOCTORS PILOTS AS WELL

Professional and businessmen are turning increasingly to the airways for fun and business trips, say flight instructors. Several Genesee County Medical Society members who are pilots are Ernest Griffin, M.D., Albert MacPhail, M.D.; Richard Schaefer, M.D.; Virgilio Villarreal, M.D.; Philip Seven, M.D.; Grant Murphy, M.D.; Ronald Smalley, M.D.; Burnell Adams, M.D.; Robert Helferty, M.D.; Cory Cookingham, M.D.; Jack Thompson, M.D., and Ralph Steffe, M.D. Doctor Steffe is owner of Flint Air, Inc., where most of the M.D.-flyers are based.

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PSYCHIATRIC STAFF

Lyle M. Allis, M.D. Robert J. Bahra, M.D. Dean P. Carron, M.D.

James R. Driver, M.D. Stuart M. Gould, Jr., M.D. Leonard E. Himler, M.D.* Francis M. Daignault, M.D. Sydney Joseph, M.D. Gordon C. Dieterich, M.D. Jacob J. Miller, M.D.

Rudolf Nobel, M.D. Richard D. Watkins, M.D. Stephen C. Mason, M.D. Philip M. Margolis, M.D. Hubert Miller, M.D.

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- MEDICAL DIRECTOR: For well established Health Department in Allegan County, Allegan, Michigan, serving 60,000 population. Requires: M.D. Salary commensurate with experience. Benefits: Paid vacation, holidays, sick leave and retirement program. Please write: John Pahl, Acting Director, Allegan County Health Department, Allegan, Michigan 49010.
- ALPENA, MICHIGAN Middle aged Generalist with General, Gynecological and Traumatic Surgical practice retiring due to failing health. \$40M to \$60M gross annually prior to restriction of activities. Excellent opportunity for a Generalist with two years Residency in General Surgery or Gynecology. Modern office building one block from center of city, complete with office equipment and clinical lab., excellent office staff; office and in-hospital surgical instruments. 200 bed modern Accredited Hospital. Complete records for 29 years. Will rent, lease, or sell building and equipment; will introduce and help in obtaining staff appointment. Will assist in financing. This is not an opportunity for a Generalist without special training as outlined above. Contact: John W. Bunting, M.D., 110 N. First St., Alpena, Michigan.
- MEDICAL DIRECTOR Single County Health Department; with 40 employees, population 165,000. VD, TB, and general health programs. Good relations with local physicians. Excellent recreational and school facilities. If under age 50 require MD or DO degree and obtain MPH within 3 years with state assistance. Over age 50, require 9 weeks of special courses over 3 years in lieu of MPH. Salary range \$23,000 to \$27,500. Starting rate depends on qualifications and experience. Usual fringe benefits. Send application and resume to Acting Director, James V. Wells, Muskegon County Health Department, County Building, Muskegon, Michigan 49440.
- PEDIATRICIAN needed for a new agency for the mentally retarded located in suburbia between Ann Arbor and Detroit. Must be progressive in his thinking and have a desire to participate in clinical investigation. An on-going research program in genetics exists with many opportunities to consult and work with physicians from nearby universities. Must be board certified or board eligible in pediatrics and eligible for Michigan licensure in medicine. Annual Salary \$20,796 \$27,290 (effective July 1, 1969) depending on education and experience. All Michigan Civil Service Benefits. For further information contact Chief of Medicine, Plymouth State Home, Northville, Michigan. An equal opportunity employer.

- GENERALISTS AND PSYCHIATRISTS In accredited progressive 2000 bed mental hospital with approved psychiatric residency training program. Ideal living in active resort community located in Michigan's screne, scenic water-wonderland. Salary \$22,550-\$30,464, depending on qualifications. (Salary rates effective July 1, 1969) Unparalleled retirement and fringe benefits. Contact M. Duane Sommerness, M.D., Superintendent, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.
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- MULTI-DOCTOR well established industrial clinic seeks physician interested in the office treatment of trauma and in Workmen's Compensation cases for new suburban branch. Remuneration highly competitive, fringe benefits, regular hours. Michigan license necessary. We are looking for a permanent associate. Send resume to: Robert R. Silver, M.D., 60 W. Hancock, Detroit, Michigan 48201 or call collect: (313) TE 1-3130.
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- 1. Microtone, factory reconditioned, best offer.
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- 3. Burroughs Medical Office Bookkeeping Machine, series 100, used, excellent condition, best offer. Phone: Charlotte, (517) 543-3200.
- Internist, General Practitioner, OB-GYN, Orthopedist, Urologist needed for additional staff to established 15-man medical group in Detroit. Excellent professional relationships. Guarantee of \$25,000 minimum, plus bonuses. Reply to Box 7, 120 West Saginaw St., East Lansing, Michigan 48823.

ANN ARBOR-YPSILANTI AREA. 3 year AMA approved, university affiliated psych. residency offering comprehensive MH services to SE Mich. Teaching faculty & supervisors include U of M faculty, private psychiatrists & analysts, as well as hospital staff. Resident's time divided approx, equally between didactic seminars (including supervision) & clinical experience. First year ADM & Intensive Treatment Units; second and third year assigned Community Psych. and/or OPC and/or Children's unit. Additional experience in psychosomatic medicine, Univ. Mental Hygiene Clinic, and neurology. 3-Year: \$10,669 to \$19,522. 5-Year \$12,152 to \$23,000. \$15,000 NIMH grants available eligible physicians in practice 4+ years. Contact: J. Tiziani, M.D., Ypsilanti State Hosp., Ypsilanti, MI 48197.

DOCTOR ASSOCIATE wanted, good opportunity, town of 10,000 with drawing of 30,000. Write Box number 6, 120 West Saginaw Street, East Lansing, Michigan 48823.

HOUSE PHYSICIAN: 300 bed general hospital. Immediate opening. Excellent salary and fringe benefits. Excellent possibility for greater development, immediate future. Contact Administrator's Office, Outer Drive Hospital, 26400 Outer Drive, Lincoln Park, Michigan. Telephone - DUnkirk 6-2000, Ext. 222.

ANESTHESIOLOGISTS: (Two) to join two other M.D.'s in fee for service, private practice in city of 100,000 approximately 90 miles from Detroit. Ten minutes to Hospitals from all locations. Professional corporation already formed with profit sharing plan and disability insurance as additional benefits. Financial remuneration excellent. No obstetrical anesthesia. Reply, Box # 8, 120 West Saginaw St., East Lansing, MI 48823.

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- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

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BY HERB AUER, EXECUTIVE EDITOR

Reports filter back to Michigan about the University of California School of Medicine and Dean C. John Tupper, formerly of Michigan, and his efforts to produce family practice specialists. Dean Tupper has established a department of community health and a department of family practice, where students will get experience in the role of the generalist. The Davis school plans to create satellite community health centers in deprived areas that cannot attract private practitioners but where students will work as part of a team of physicians, nurses, and social workers, participating in periodic examinations, immunizations, and home visits.

A strong appeal that all physicians support the AMA is made by AMA President Dwight L. Wilbur, M.D. In part, he has declared: "Every scientific specialty of medicine, every career in medicine, every geographical area, is represented in the House of Delegates, which is the policy-making body of the AMA and consequently, is the principal policy-making body of all of medicine.

"Only if all of us work together can medicine divise the best possible program for the future of total health care."

Rural Michigan physicians will say "amen" to the views expressed by Harold Margolies, M.D., of the AMA staff, at the 1969 Conference on Rural Health. In part, he said, "Today rural America knows that all Americans are supposed to have equal rights, that laws have been passed to extend these rights to include decent medical care, and that many are benefiting in ways they are not. Their expectations remain modest; they do not expect a Mayo Clinic in every county seat,

but they want modern care provided them when it is needed. They are less concerned about the costs than they are the availability of medical treatment. Sorrowfully, they also understand why they cannot attract physicians and nurses. They have seen too many of their own children depart, and, some of the oldtimers as well."

The following is a quote from a recent issue of the Journal of the American Hospital Association: "Education is just now coming of age in America's hospitals. Less



time is spent justifying the need for education, while more time is spent in a careful examination of all aspects of training and education, with an eye on expected performance. Many traditional educational practices are being questioned by the leaders of a pressureweary system as they respond to imminent crisis."

The pedestrian accounts for 18 per cent of the nation's 50,000-plus traffic fatalities each year, according to a report just published by the University of Michigan Highway Safety Research Institute. Anatomy Professor Donald F. Huelke studied 286 pedestrian fatalities in Detroit and suburban Wayne County and found that 37 per cent (106 victims) were crossing a street outside a crosswalk or in the middle of the block. An additional 36 per cent (102) were crossing at intersections, however. The remaining 27 per cent were standing or walking in the road-

Alcohol was the single factor most commonly associated with victims.

Medicenters of America, which will construct an extended care facility at Detroit Providence Hospital uses an interesting slogan on all its mail from its headquarters at Memphis. The slug on all metered mail reads: "Private Enterprise Dedicated to Better Health Care."

Went through a town that was so small the other day that a road sign warned: "Slow, No Hospital."

Which Man Are You?

Theodore Roosevelt, 26th president of the U.S. (1901-1909), emphasized the need for persons to try to improve politics rather than merely find fault:

"It is not the man who sits by his fireplace reading his evening paper and saying how bad our politics and politicians are who will ever do anything to save us; it is the man who goes out into the rough, hurly-burly of the caucus, the primary, the political meeting, and there faces his fellows on equal terms.

"The real service is not rendered by the critic who stands aloof from the contest, but by the man who enters it and bears his part as a man should."

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Lactinex contains both Lactobacillus acidophilus and L. bulgaricus in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin. 1,2,3,4,5,6,7,8

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

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(LX-DS)

References:

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

JULY 1969 ' ● VOLUME 68 ● NUMBER 14

SEE CENTER PAGES
FOR TIME TABLE
OF ANNUAL SESSION EVENTS

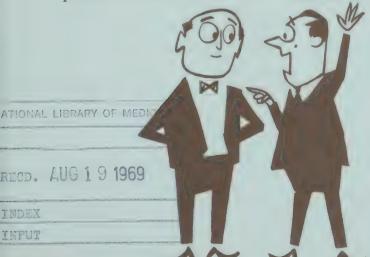
Current Controversies In Medicine Feature of 1969 Annual Session

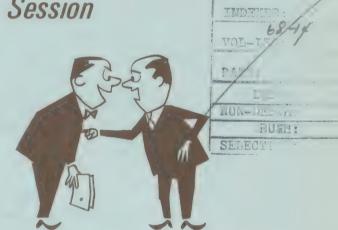
The opportunity to hear both sides of controversial medical issues will be offered to interested physicians attending pertinent sections of the 1969 MSMS Annual Session which runs Sept. 28-Oct. 2.

"Current Controversies In . . ." is the general title for the two discussions on the first morning of the Scientific Sessions, Wednesday, Oct. 1. Two men, each representing the opposite views of the issues, will make their points in the Reception Room of the Sheraton-Cadillac Hotel, Detroit, location of the five-day Annual Session.

"Marijuana – Freedom or Control?" is the subject of the first discussion, set at 9 to 10 a.m. After intermission to view the scientific exhibits on display, a debate will follow on "Sensationalism and Scientific Communication," from 10:45 a.m. to noon.

Representing opposite viewpoints on the marijuana issue will be Paul Lowinger, M.D., associate professor of psychiatry, Wayne State University School of Medicine and chief of Outpatient Service at Detroit's Lafayette Clinic, and Herbert A. Raskin, M.D., Southfield. Doctor Raskin is adjunct associate professor of psychiatry at WSU, chairman of the MSMS Committee on Alcohol and Drug Dependence, member of the AMA Committee on





Alcoholism and Drug Dependence, representative of the National Coordinating Council on Drug Abuse Education and Information and member of the Detroit Mayor's Committee on Rehabilitation of Narcotic Addicts.

"Sensationalism and Scientific Communication" will be the topic of Frank Chappell, M.D., Dallas, and Donald R. Kahn, M.D., Ann Arbor, associate professor of thoracic surgery, the University of Michigan Medical School and a member of the university's cardiac surgery team. Doctor Chappell is Director of Medical Information, The University of Texas Southwestern Medical School at Dallas, a fellow of the American Medical Writers Association, member of the National Association of Science Writers and a member of Sigma Delta Chi Journalism Society.

Questions from the audience will conclude each presentation. Arrangements have been made by Alexander J. Walt, M.D., Detroit, associate dean and professor and chairman of the Department of Surgery, WSU School of Medicine.

In addition to these special new "Current Controversies In . . ." offerings, the MSMS Scientific Sessions Oct. 1 and 2 will present the traditional general sessions, specialty meetings and four all-day postgraduate courses. The full program is printed in the center fold of this issue.

Timetable of Events for 1969 MSMS Scientific Session Oct. 1-2, Sheraton Cadillac Hotel, Detroit

	GENERAL SESSIONS	SPECIALTY MEETINGS	OTHER SPECIAL EVENTS		ADUATE COURSES, LTON HOTEL
WEDNESDAY OCTOBER 1 MORNING	SURGICALLY CORRECTABLE FORMS OF HYPERTENSION Primary Aldosteronism Pheochromocytoma Renal Artery Stenosis Endocrine and Renovascular Hypertension, Panel CURRENT CONTROVERSIES IN Marijuana — Freedom or Control? Sensationalism and Scientific Communication SUBCUTANEOUS MASTECTOMY WITH PROSTHETIC RECONSTRUCTION	UROLOGY Carcinoma of the Bladder DERMATOLOGY Malignant Melanoma — Diagnosis and Therapy		1. CARDIOVASCULAR PHARMACOTHERAPY Continuous from 9-5	2. MEDICAL AND SURGICAL EMERGENCIES Continuous from 9-5
LUNCH			GENERAL LUNCHEON The Negro Physician		
AFTERNOON	NEUROLOGIC PROBLEMS IN CHILDREN, PANEL THE EFFICIENT USE OF BLOOD AND BLOOD COMPONENTS	PLASTIC SURGERY Hypospadias and its Surgical Repair PHYSICAL MEDICINE PROCTOLOGY Diagnosis and Treatment of Granular Proctitis RADIOLOGY			
	OXYGEN — IS IT NECESSARY?	OPHTHALMOLOGY OTOLARYNGOLOGY Oral Lesions: Diagnosis and Management PUBLIC HEALTH AND PREVENTIVE MEDICINE The Epidemiology and Preventive Medical Aspects of Accidents GASTROENTEROLOGY Bile Salt Metabolism and Liver Injury ANESTHESIOLOGY Belladonna Drugs PEDIATRICS The Use of Electroencephalography and Clinical Evaluation for Assessment of High Risk and Low Birth Weight Infants			
EVENING			STATE SOCIETY DINNER DANCE		
THURSDAY OCTOBER 2 MORNING	THE RELATIONSHIP OF MATERNAL NUTRITION TO FETAL DEVELOPMENT WHAT'S NEW IN THE PRACTICE OF The Chemotherapy of Cancer Hematology Allergy Gastro-Intestinal Diseases Infections and Antibiotics Rheumatology Pediatrics	PATHOLOGY ALLERGY AND APPLIED IMMUNOLOGY Immunotherapy of Ragweed Hay Fever	MOOT COURT	3. OFFICE ORTHOPEDICS Continuous from 9-5	4. RENAL DISEASES Continuous from 9-5
	Diabetes Gynecology and Obstetrics SEPTIC ABORTION WITH ENDOTOXIN SHOCK	Thursd	ay Afternoon Pr	ogram on Page	782

Thursday, Oct. 2, Annual Session, cont.

GENERAL SESSIONS

SPECIALTY MEETINGS

LUNCH

GENERAL LUNCHEON Speaker to be Selected

AFTERNOON

PANEL ON BURNS
PANEL ON HIATUS HERNIA

PATHOLOGY

Seminar on Dermatologic (Non-Neoplastic) Lesions

MICHIGAN DIABETES ASSOCIATION

Gut Hormones, Insulin and Glucagon

Glucagon — Newer Physiological and Clinical

Aspects

THORACIC SURGERY

Surgical Treatment of Coronary Artery Insufficiency

NEUROLOGY

The Effects of I-Dopa in the Treatment of

Patients with Parkinson's Syndrome

PSYCHIATRY

Teenage Drug Patient

Violence

ORTHOPEDIC SURGERY

Stroke Rehabilitation

OCCUPATIONAL MEDICINE

Air Pollution — Carbon Monoxide

EVENING

PUBLIC FORUM

Banquet to Conclude MHC's Unique Careers Program

A banquet is planned Aug. 7 to honor the 40 Detroit inner-city high school students who have taken part in a unique six-week health careers program this summer.

The banquet, which concludes the summer program organized by the Michigan Health Council, will be hosted at Mercy College, Detroit, by Michigan Blue Cross-Blue Shield. Certificates of course completion will be presented to each youth.

Those invited include the youngsters and their parents; officials of the Chrysler Corporation Fund, which provided money for the program; trustees of Michigan Blue Cross-Blue Shield; staff members from Boulevard General, Kirwood General, Crittenton and Metropolitan Hospitals, where the program was carried out; and representatives of the Wayne County Medical Society, the Detroit Medical Society, Detroit Public Schools, New Detroit Committee, Greater Detroit Hospital Council, Detroit Commission on Children and Youth, Detroit and Michigan Chambers of Commerce.

Through the six-week program, called the Michigan Health Council's Summer Exploratory Experience in Health Professions, the Detroit students have had the opportunity to learn of careers in up to 13 different hospital departments, even watching surgery be performed.

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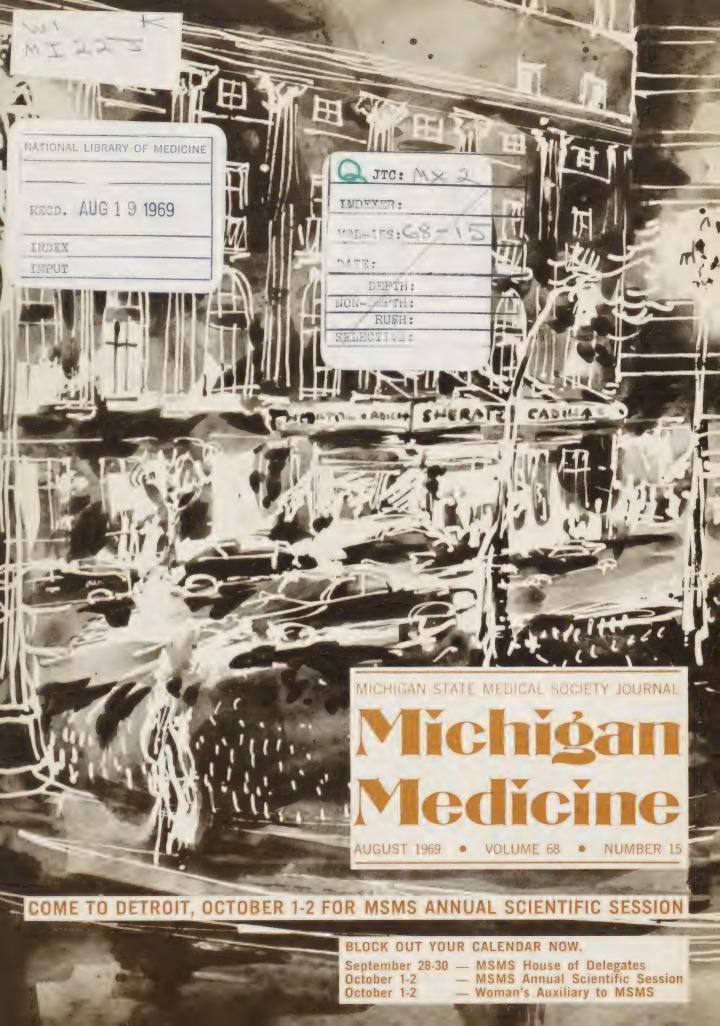
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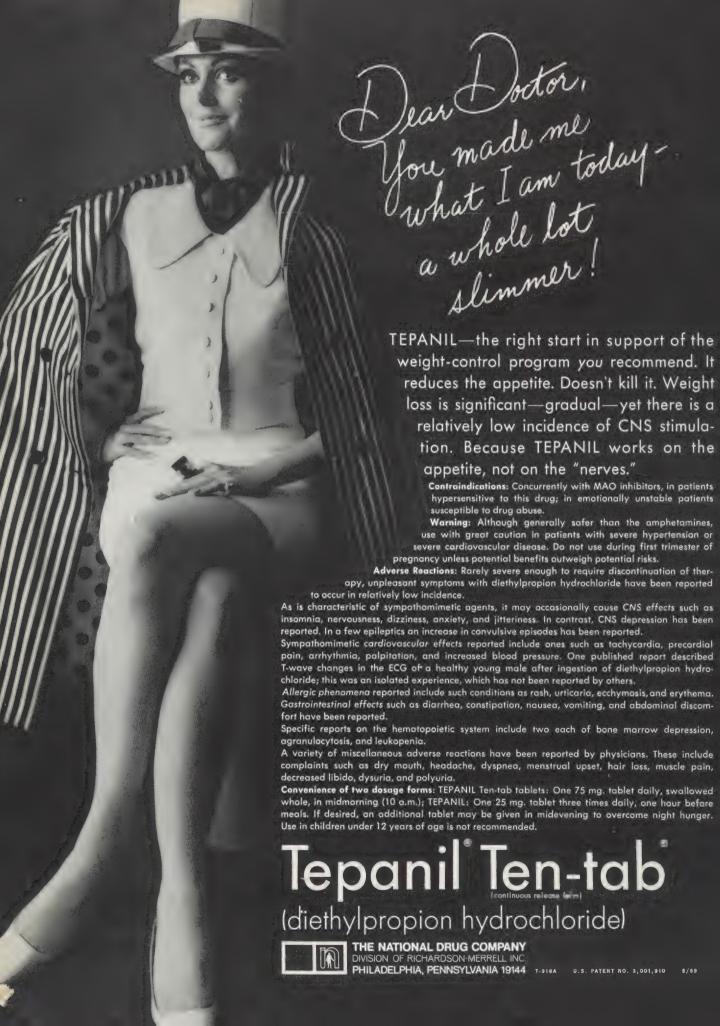
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MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

AUGUST, 1969 • VOLUME 68 • NUMBER 15

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Medical Leaders From Throughout Nation To Speak at Scientific Session Oct. 1-2

National medical leaders from many fields will speak at the two-day Scientific Session that will conclude the five-day 1969 MSMS Annual Session Sept. 28-Oct. 2 in Detroit.

The physicians will bring new viewpoints and knowledge to general sessions, specialty meetings,

COVER AND BELOW — The sketch of the Sheraton-Cadillac Hotel, which will be headquarters again in Detroit for the 1969 MSMS Annual Session, was drawn by Igor Beginin, a well-known Detroit area resident who teaches art at Eastern Michigan University. Many Michigan residents have seen work by Mr. Beginin in the Sunday magazine section of the Detroit Free Press.



all-day postgraduate courses, discussions of medical controversies and new medical developments, all scheduled in the big two-day scientific program.

They will come from Texas, Virginia, California, Maryland, Massachusetts, Ohio, Florida, Pennsylvania, Missouri, New York and Wisconsin to address Michigan physicians and their wives, interns, residents, nurses, medical technicians and university students.

Among the most outstanding of the outstate speakers will be:

Albert Sjoerdsma, M.D., Ph.D., Bethesda, Md., chief, Experimental Therapeutics Branch, National Heart Institute, National Institutes of Health;

George R. Prout, Jr., M.D., Richmond, Va., professor and chairman, Division of Urology, Medical College of Virginia, Health Sciences Division, who in September will become chief of the Urological Service, Massachusetts General Hospital and professor of surgery at Harvard Medical School;

Thomas D. Cronin, M.D., Houston, clinical professor of plastic surgery at Baylor University College of Medicine and chief of plastic surgery at Hermann, St. Luke's Episcopal and Texas Children's Hospitals;

Richard G. Farmer, M.D., of the Department of Gastroenterology at the Cleveland Clinic;

Henry P. Pendergrass, M.D., Boston, chief of radiology at Massachusetts General Hospital;

William H. Saunders, M.D., Columbus, Ohio, professor and chairman of the Department of Otolaryngology, The Ohio State University College of Medicine;

Denis Cavanaugh, M.D., St. Louis, Mo., professor and chairman of the Department of Obstetrics and Gynecology, St. Louis University School of Medicine:

George C. Cotzias, M.D., Brookhaven National Laboratory, Associated Universities, Inc., Long Island, N.Y.

Press Strongly Supports MSMS Positions On Medical School, Optional Degrees

Editors of Michigan's daily newspapers have written many words lately on the need for more doctors, the need to expand MSU's College of Human Medicine to a four-year degree-granting school, and on MSMS's own proposal to create optional MD-DO degree programs in the state's existing medical schools.

The State Journal, Lansing, published four prominent editorials in June urging the expansion of the MSU school, stating: "The legislature without question should give top priority to the MSU expansion request before giving consideration to the development of any new medical schools. The MSU question has been before the legislature for two years or more and the state cannot afford further delays."

On June 29, a Detroit Free Press editorial calling for a four-year medical school at MSU now, said that the state's committing itself to a separate school of osteopathy "would be acting with something other than boldness. Recklessness would be just about the right word."

"At a time when the Michigan Legislature is hard-pressed to finance a host of vital services and pay for all kinds of long-delayed capital outlay, how can it contemplate writing a blank check for an osteopathic college?" asked a con-

temptous *Detroit News* in a June 30 editorial. "The state's shortage of physicians provides no credible excuse. More doctors can be gained faster and at less cost by expanding the state's existing medical schools."

Comments along the same vein were printed in The Flint Journal, The Battle Creek Enquirer and News, Adrian Daily Telegram, the Kalamazoo Gazette, Bay City Times, Saginaw News and Jackson Citizen-Patriot in May and June editorials.

An excellent Flint Journal editorial June 26 stated that the welfare of the people is of prime concern in deciding whether to establish a new DO school or expand existing medical schools and that the decision should be made on logic. "The decision to expand present facilities rather than build a new osteopathic college should be obvious," it concluded.

"Setting up an expensive, separate college for osteopaths is not the answer," said the Kalamazoo Gazette on June 29. On May 1, it had called for funds to expand the MSU medical college to four years, to adopt MSMS's optional degree program at existing medical schools and to bring osteopaths and MDs under the same state licensing board, as MSMS has pro-

posed in its pending Single Medical Practice Act.

"The Bay City Times joins the Michigan State Medical Society in opposing bills which would create a separate college to train osteopaths," read that paper's editorial on June 27. The newspaper called for more doctors created through the best use of public funds and concluded that separate schools were not the best solution.

The Saginaw News hoped on June 24 that "somebody in Lansing gets the message before the Legislature finalizes a foolish mistake and puts its stamp of approval on a separate college for osteopathic medicine. The MSMS grasps the problem in full round as it applies to Michigan's doctor shortage which is critical—and getting worse by the year," added the editorial.

More support has come from the Jackson Citizen-Patriot, which June 23 endorsed the optional degree plan and observed that the legislature hadn't taken "official cognizance of the willingness of Michigan's existing and proposed medical schools to train osteopaths along with medical doctors."

The Ann Arbor News called the optional degree program "a reasonable compromise," and said the cost of starting an osteopathic college from scratch would be "staggering, neither good sense nor fiscally responsible."

On the subject of more doctors in general, the Adrian Daily Telegram and the Battle Creek Enquirer and News both warned their readers of the growing crisis of too few doctors, the latter deploring the legislature's unwillingness to grant funds to expand MSU's medical school and concluding "However the funds are to be raised, the point is clear that Michigan must assign an urgent priority to accelerating its graduate doctor production."

WSU Board Proposes DO Degree in Med Program

The Wayne State University Board of Governors has proposed a program leading to the Doctor of Osteopathy degree to be offered in the WSU School of Medicine.

The additional expansion of physician training to include doctors of osteopathy, according to the Board of Governors, could be carried out rapidly, effectively and at relatively low cost.

The plan follows the lines of the MSMS argument for an optional MD-DO degree to be offered at the state's existing medical schools, rather than establishment of a new osteopathic college.

Doctors Mellis, Margolis Stress Need For Sex Education in Schools

MSMS sponsored a news conference with two MSMS leaders as spokesmen for the medical point of view on the day after the State Board of Education hearing July 8 on proposed new guidelines.

Richard T. Mellis, M.D., Kalamazoo, chairman of the MSMS Lay Education Subcommittee of the Maternal Welfare Committee, described the Lansing hearing as a "circus."

Frederick J. Margolis, M.D., Kalamazoo, nationally-recognized family life authority, called the display "an odious thing, about as far from the democratic process as anything I have seen."

At the news conference Doctor Mellis and Doctor Margolis reviewed the main points of the Citizens Advisory Committee's guidelines, saying that sex education is a health issue, not a political issue.

They deplored the "use of extremist tactics to create fear" by the opponents and the "John Birch Society characteristics" exhibited by the spectators.

"The tragedy of it is, the opposition is a political movement to frighten and scare people into believing that teachers are trying to do something to the morality of their children," said Doctor Margolis.

Doctor Mellis stated that the guidelines are an excellent piece

Emergency MD's Prepare to Ask For State Charter

Michigan's emergency physicians are preparing a constitution and by-laws and planning to select a slate of officers in time to request a charter at the next quarterly meeting in November of the American College of Emergency Physicians.

The work is underway following a recent organizational meeting of the state group, held in June at MSMS headquarters.

of work and are comprehensive and complete. Doctor Margolis commented that they will probably be the basic example of guidelines for sex education throughout the country.

Physicians are vitally interested in the sex education issue because they see in their offices the tragic mistakes of a lack of sex education, the doctors pointed out.

Work done by MSMS's Lay Education Subcommittee of the Maternal Health Committee was among the reports and studies reviewed by the Citizens Advisory Committee in drawing up their guidelines.

Early in the spring, MSMS became aware of the move to dis-

credit sex education in the public schools and Doctor Mellis's committee sent a letter to all public school superintendents informing them that the attacks were under the direction of the John Birch Society. The letter urged the school administrators to seek the aid of concerned local physicians in combating the smear campaign.

Before that, early attempts were made to stimulate physicians to do more at the local level and to enlist community organizations in working with sex education evaluations and programs, reported Doctor Mellis and Margolis at the news conference. MSMS and the AMA issued a joint resolution in 1964 regarding sex education.



OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, September 28-Oct. 2, 1969. The provisions of the Constitution and Bylaws and the Official Program will govern the deliberations.

JAMES J. LIGHTBODY, M.D. President

ROSS V. TAYLOR, M.D. Council Chairman

JAMES B. BLODGETT, M.D. Speaker

VERNON V. BASS, M.D. Vice Speaker

Attest:

Kenneth H. Johnson, M.D., Secretary

LEGISLATURE HONORS DOCTOR NELSON

The Michigan legislature recently passed a concurrent resolution honoring Robert B. Nelson, M.D., Ann Arbor, retired senior associate director of University Hospital.

The resolution recognized Doctor Nelson's "many outstanding and brilliant contributions to the hospital and to medicine, and stated that at Doctor Nelson's retirement "the University of Michigan will have lost an outstanding and dedicated medical director and administrator who will be sorely missed."

MSMS Committee Issues Sensitivity Training Warning

The MSMS Mental Health Committee, chaired by Benjamin Jeffries, M.D., Harper Woods, has issued a warning to the public about so-called "sensitivity programs" and urged that physicians play a part in assuring the programs' scientific validity.

The committee has heard complaints that some group instructional leaders of sensativity training (laboratory learning) sessions are not professionally qualified to recognize hazardous consequences to some participants.

"The medical profession," says Doctor Jeffries, "has the ethical responsibility to alert any person or persons interested in participating in this type of program to the necessity of qualified leaders.

Interested educators, churchmen, businessmen and others are being encouraged to contact their county medical societies or MSMS for further information. MSMS has sent information to every county medical society president.

MDA Elects New Leader

New executive director of the Michigan Dental Association is John G. Nolen, D.D.S., East Lansing, who has been MDA secretary since 1962.

COUNTY SOCIETIES URGED TO IMPROVE COMMUNITY TIES

The MSMS Council has sent a general recommendation to each county medical society to set up a pattern and procedure whereby leaders "confer at least once each year with the president of each local association—such as the chamber of commerce, hospital board of trustees, farm bureau, PTA council, council of churches, etc.

"We believe this official basis permits county societies to express concern over someone else's problems and to informally explain situations which are disturbing to medicine," says Brock E. Brush, M.D., chairman of the MSMS Public Relations Committee.

The PR Committee would appreciate hearing from the county medical societies that carry out this kind of face-to-face communications effort and can offer suggestions to others who would like to try it, report on new cooperative relationships developed and relay the concerns other groups express to county societies. MSMS is eager to help county societies implement new cooperative health care efforts.

The suggestion was recommended to The MSMS Council by the MSMS Public Relations Committee.

MSMS Delegates At AMA Meeting

MSMS was well represented at the recent AMA Annual Meeting. MSMS Delegates who participated were Donald N. Sweeny, Ir., Detroit, chairman; Sidney Adler, M.D., Detroit; Otto K. Engelke, M.D., Ann Arbor; John R. Heidenreich, M.D., Daggett; Luther R. Leader, M.D., Birmingham; Robert E. Rice, M.D., Greenville; George W. Slagle, M.D., Battle Creek; Joseph A. Witter, M.D., Highland Park; and Alternate Delegates Vernon V. Bass, M.D., Saginaw; John J. Coury, M.D., Port Huron; James C. Danforth, Jr., M.D., Detroit; Bradley M. Harris, M.D., Ypsilanti; Paul T. Lahti, M.D., Royal Oak; John W. Moses, M.D., Detroit, and Marjorie Peebles-Meyers, M.D., Detroit.

MD-PAC WORKSHOP NOW NOV. 8

Jack M. Stack, M.D., Alma, chairman of the annual MD-PAC Political Workshop, announces a change in the date of this year's event from Nov. 1 to Nov. 8. The session, which will kick off Medicine's 1970 political campaign in Michigan, is scheduled for the City Club of the Jack Tar Hotel, Lansing.

Emphasis will be given to political education technique and organization, Doctor Stack reports.

MCP, INTERNISTS SET JOINT MEET IN SEPTEMBER

The Michigan Section of the American College of Physicians and the Michigan Society of Internal Medicine will meet concurrently in September at the Grand Hotel on Mackinac Island.

The internists' annual scientific meeting is scheduled Sept. 18-21 and the Michigan ACP section scientific meeting will run Sept. 19-21.

Muir Clapper, M.D., Detroit, American College of Physicians governor for Michigan, is general chairman of the internists' meeting. A special guest will be Samuel P. Asper, M.D., Baltimore, ACP president and professor of medicine at Johns Hopkins University School of Medicine.

MSU STUDENTS SERVING U. P. HEALTH PROJECTS

Six medical and health-related students from Michigan State University are in the western Upper Peninsula for a unique summer program of community service and study. The program is part of a continuing affiliation between the Western U. P. Health Services Council and the university.

The Council plans development of comprehensive medical care services in the area.



The Physician's Responsibility As A Citizen

No one can question the high quality of the scientific knowledge and technical skills of today's physicians. Criticism is sometimes heard, however, with respect to the quality of our citizenship.

By tradition and training, physicians are prepared to accept and use the veritable explosions in scientific knowledge of the past few decades, but we generally are *not* prepared for the explosions in the socioeconomic fabric of our society.

Accustomed to a wholly private doctor-patient relationship, physicians have concentrated on providing the highest possible standards of medical care. Problems of distribution of medical care were minimal in the past, but today they are monumental and the federal government is dominant.

THEREFORE, PHYSICIANS MUST take a more active part in public affairs for at least three reasons: First, we owe it to our profession to insure its future and safeguard the conditions under which we can best use our knowledge and skills.

Second, we owe it to our patients. The person with stubborn arthritis or vague chest pain frequently has something else bothering him, too. Perhaps he has a boy in Vietnam or inflation has eaten up half of his life savings. To help him with his whole medical problem, we must pay more attention to the national and world problems that affect him adversely, and try to influence his environment in the direction of making it more favorable to his well-being.

Michigan Medicine presents a special article this month on the President's Page. The author, a former U.S. congressman from Minnesota, now resides in Washington, D.C., and travels about the country delivering speeches. The article is excerpted, with permission of the publisher, from Texas Medicine, the journal of the Texas Medical Association.

Third, we owe it to ourselves. Before we are physicians we are trustees, as well as beneficiaries, of a great heritage of freedom, a set of values, and a way of doing things that is called the American philosophy of life and government. The political and economic order is under assault from without and within, and it is losing ground.

A wise man named Jesus said, "Seek and ye shall find." Many today say, "Sit down, the government will bring it to you."

THE THOUGHTFUL CITIZEN should ask three questions: First, can the government do everything? Hitler and Stalin both tried, but got a threatened breakdown in production. Their successors had to decentralize to provide greater personal initiative and incentive, and then production went up. Recently, some of our own officials have begun saying that there are some things the government cannot do without the all-out efforts of the private sector. This recognition, however belated, is encouraging.

Second, would it be good if the government could do everything? Do you make people more independent and self-reliant by making them

more dependent?

Third, what about the poor, the unfortunate, and the needy? The government should help them, and generously. But this does not mean that assistance should be given to all, whether they need it or not.

These larger issues are decided in the political arena, and nowhere else. It is hard to justify any physician's thinking that he is too busy to work at government — which means in politics.

Government today determines the conditions of our lives as well as of our practice. And government is determined by what we do or don't do in politics.

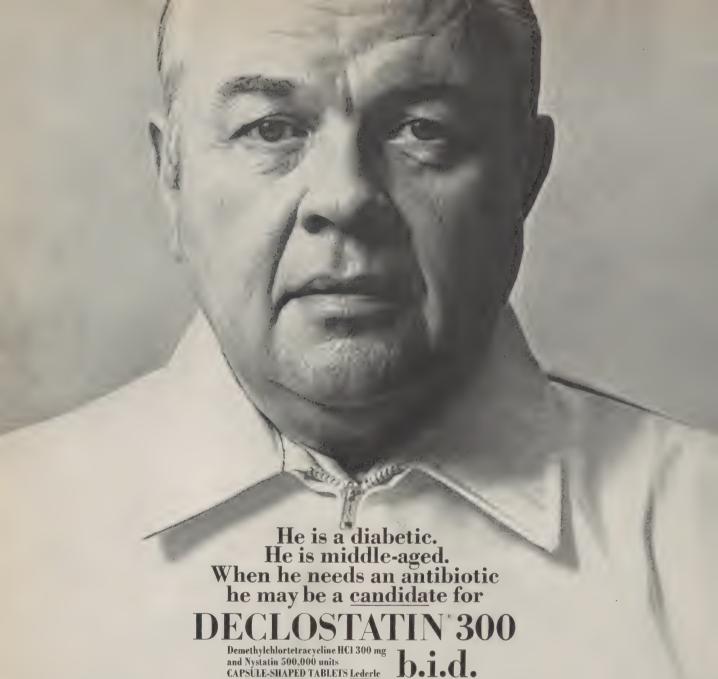
TO WORK EFFECTIVELY in politics, you must study issues, spread and sharpen your views by discussion with other citizens, and join a political party — the one you think is *nearest* right on the most important issues.

The most wonderful thing about our country, the thing that we must preserve at all costs, is the privilege of changing things we don't like. Wherever conditions are bad, or don't meet our standards, we can correct them -if we will work in politics!

This requires generous investment of *money*, as well as time, thought, and effort. Give generously of your money, voluntarily, to support the kind of government in which you believe, or you can be sure that more money will be taken from you in taxes for the kind of government you oppose.

The way to begin is with ideas and principles, get persons and parties committed to them, translate them into political programs, provide funds, and put the programs into practice.

Walter H. Judd, M.D. Washington, D.C.



To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

<u>Precautions</u>: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—uriticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any hone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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DOCTOR HOLLY DISCUSSES BLUE SHIELD

To the Editor:

More wood for the fire!

Brooker Masters, M.D., hereinafter called Brooker, asks why only 68.3% of Michigan physicians participate in Michigan Blue Shield.

Well, Brooker, why don't they? Asking the question is not enough!

Put another way, why do physicians in some other states (not all, mind you!) participate so completely in their particular state's Blue Shield plan? Do they have something we don't have?

It might just be.

Some state Shield plans pay on the doctor's statement—no insurance form! Other state plans pay in 1/2 or less than than our Michigan plan. These facts alone should lead physicians to suspect the presence of other good reasons other state's physicians join such considerate and thoughtful programs.

Then, too, there's that 5% of premium income figure for operational costs of Michigan Shield. Isn't that just great! But why so low?

Brooker, and many other physicians (almost all) make this low overhead possible for Blue Shield by absorbing Shield's operational costs in their own practices. It is there that the paperwork and patient problems are handled. It is there that the time consuming claim trouble-shooting and patient's questions produce the frustration headaches and long hours.

What cash break do physicians give a patient or an insurance company who pays cash immediately, 30 days, or even 60 days as long as the only physi-



EDITORIAL VIEWS

cian's office operation is a ledger record and a bill copy?

The answer is, none.

So, perhaps physicians should start putting those paper costs where they belong by adding, say, 8% (or some flat fee) to the charge for completing any and all forms. Physicians might then be able to drop some of the fees they have raised to the cash customers or maybe forestall further inroads of inflation by only increasing fees to the customers who require special consideration for bill payment.

You know, however, I have a funny feeling that somehow the press would get hold of such charge increase information and it would appear in print something like this: "Blue Shield maintains operational costs at 5% of income but doctors' fees have gone up 8%."

Sure, Brooker is right, third parties are here to stay. So are physicians. So are patients. Hopefully, however, less permanent are the needs for prompt payment of *all fair* fees, a simple universal billing system, and a clear definition of who is responsible to whom for what, to mention only a few. In the patient-physician-Michigan Blue Shield relationship, payments are slow and error laden, billing is tedious and responsibilities are greatly confused.

There is a cure advocated by some; that is, divorce physicians from Blue Shield and establish a relationship between them just as it is between physicians and all other third party payors. This may be the only cure.

Answer the following, please!

Can Blue Shield present the collective face of Michigan physicians to the public? Can Blue Shield effectively represent Michigan physician's true interests at the bargaining table with industry, labor or the federal government?

If the answer to these questions is no, or there is any doubt, Blue Shield is not and cannot be a bulwark against federal or any other "control." In fact, Blue Shield might be more effectively used by any one of those groups for "control."

And there we are.

But not quite.

Each physician should try to see clearly and choose a position from a combination of his own experiences and beliefs with what he hears and sees. Then physicians should speak collectively for themselves through the Michigan State Medical Society House of Delegates. Better yet would be an individual poll of physicians in this important matter of the Michigan physicians' relationship to Michigan Blue Shield.

Yes, Brooker, it is time we get things straightened out!

Very truly yours, Leland E. Holly, II, M.D. Muskegon "Shall I order Maalox?"

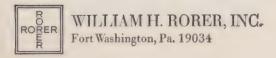


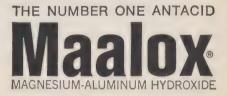


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It is interesting to note that the incidence of congenital heart disease nearly approaches that of rheumatic disease. This should give cause for thought in those seeing children with heart murmurs. John W. Moses, M.D., Scientific Editor

The Michigan Rheumatic Fever Study: Clinical Characteristics of Children Attending MDPH - Sponsored Cardiac Field Clinics

BY WALTER G. PARKER, M.D., M.P.H. ANN ARBOR

For several years the Michigan Heart Association's Rheumatic Fever Control Committee has been concerned with the extent of rheumatic fever in Michigan and with the effort the organization should give to the prevention and treatment of rheumatic fever and rheumatic heart disease.

Many physicians hold the view that rheumatic fever no longer remains a significant public health problem and report that they see little or no rheumatice fever in their practices. A further indication of the decreasing emphasis on rheumatic fever was observed in 1967 when the Michigan State Medical Society closed its three rheumatic fever centers and discontinued its Rheumatic Fever Control Program.

In an effort to assess the importance of rheumatic fever as a public health problem, the Michigan Heart Association, in conjunction with the Michigan Department of Public Health and the University of Michigan School of Public Health, in August 1967 undertook a comprehensive study of services and facilities available to children and young adults with heart disease and rheumatic fever in Michigan.

MICHIGAN HAS a rheumatic fever prophylaxis program and maintains a registry of rheumatic fever and rheumatic heart disease patients. Over 1000 cases of rheumatic fever are reported to the State Health Department each year.³ In making a request for monthly bicillin or oral sulfa prophylaxis, the physician completes a form listing his criteria for making the diagnosis of rheumatic fever. No other effort is made to confirm the diagnosis

nosis of rheumatic fever or rheumatic heart disease.

In September 1964 the Michigan Department of Public Health set up its cardiac field clinics. The purpose of these clinics is to provide medical consultation for children under the age of 21 who have or are suspected of having heart disease. All patients are referred by their family physicians. At the close of 1967 over 700 patients had been seen in the cardiac field clinics. Clinics have been held in 16 different areas of Michigan, and efforts are made to hold each clinic yearly in the same location.

SEVERAL APPROACHES have been taken in studying the problem of rheumatic fever in Michigan; one of these has been a comprehensive study of the cardiac field clinics. The purpose of this report is to describe the clinical characteristics of patients attending the clinics from September 1964 through December 1967, to assess the extent of rheumatic fever and congenital heart disease with-



SCIENTIFIC PAPERS

Doctor Parker is research associate in Maternal and Child Health in the School of Public Health at the University of Michigan. His research was supported by a grant from the Michigan Heart Association with headquarters in Detroit.

TABLE 1
PATIENTS VISITING CARDIAC FIELD CLINICS

Year	Number of Patients	Percent
1964	96	13.3
1965	127	17.6
1966	288	39.9
1967	211	29.2
Total	722	100.0

TABLE 2

LOCATION OF CARDIAC FIELD CLINICS AND ATTENDANCE

Clinic	Number of Patients	Percent
Marquette	145	20.1
Saginaw	106	14.7
Monroe	93	12.9
Port Huron	57	7.9
Alpena	54	7.5
Escanaba	42	5.8
Sault Ste. Marie	37	5.1
Frankfort	29	4.0
Harbor Beach	29	4.0
Cadillac	28	3.9
Houghton	23	3.3
Ludington	20	2.8
Ironwood	19	2.6
South Haven	18	2.5
Bay County	11	1.5
Iron Mountain	10	1.4
Total	722	100.0

TABLE 3

PATIENTS ATTENDING CARDIAC FIELD CLINICS
BY AGE AND SEX

	AGE		S	EX			
		M	ale	Fer	nale	Total Po	pulation
		No.	%	No.	%	No.	%
1.	under 1	19	40.0	27	60.0	46	6.3
2.	1 - 2	26	57.8	19	42.2	45	6.2
3.	3 - 4	43	64.2	24	35.8	67	9.3
4.	5 - 6	58	48.7	61	51.3	119	16.5
5.	7 - 8	32	49.2	33	50.8	65	9.0
6.	9 - 10	37	48.0	40	52.0	77	10.7
7.	11 - 12	49	59.0	34	41.0	83	11.5
8.	13 - 14	35	41.2	50	58.8	85	11.8
9.	15 - 16	41	54.0	35	46.0	76	10.5
10.	17 - above	38	64.4	21	35.6	59	8.2
	Total	378		344		722	100.0
		(52.49	6)	(47.69	6)		

in this population, and to further describe the operation of these clinics.

METHOD OF APPRAISAL

All patients visiting the cardiac field clinics were referred by their private physicians. In most instances the referring physician supplied a medical history. In those instances in which medical care had been provided by the State Health Department's Division of Services for Handicapped Children (Crippled Children's Program), the complete agency medical record was available.

The clinics were usually held on one or two days in a local hospital that provided examination

TABLE 4
REASON FOR CARDIAC REFERRAL

		Number	Percent
1.	Heart Murmur (asymptomatic)	286	39.9
11.	Rheumatic Fever or Questionable	,	-
	Rheumatic Fever	214	29.9
	history of Rheumatic Fever	151	21.1
	sub-cutaneous nodules	21	2.9
	acute illness during past year foll	owed	
	by detection of heart murmur	18	2.5
	Rheumatic Heart Disease follow-u	p 15	2.1
	suspicion of Rheumatic Fever or		
	Rheumatic Heart Disease	5	0.7
	acute Rheumatic Fever	4	0.6
Ш.	Congenital Heart Disease	109	15.2
	follow-up of Congenital Heart Dis follow-up of Congenital Heart Dis		8.9
	post-operatively	45	6.3
IV.	Other Cardiac Symptoms or Signs	107	15.0
	Total	716	100.0

TABLE 5

INITIAL INDICATION OF HEART DISEASE BY AGE, PERIOD, OR CIRCUMSTANCES OF EXAMINATION

		Number	Percent
ı.	Routine Examination	259	24.5
	routine examination — recently	108	16.6
	pre-school examination	35	5.4
	pre-athletic examination	15	2.3
	Selective Service Exam	1	0.2
11.	Heart Disease Recorded as Known Sin	ce: 392	60.2
	(Details Not Available)		
	school period (6-10 years)	104	16.0
	early infancy	78	12.0
	pre-school (2-5 years)	77	11.8
	birth	61	9.4
	early adolescence (11-15 years)	44	6.8
	late infancy	25	3.8
	late adolescence	3	0.4
III.	Suspected after Acute Illness	99	15.3
	acute illness within last year following Rheumatic Fever (age po	74	11.4
	not known)	22	3.4
	illness at time of field clinic visit	2	0.3
	during recent pregnancy	1	0.2
	Total	650	100.0

rooms, X-ray, electrocardiographic and laboratory facilities. All examinations were performed by pediatric cardiologists, and over 90 percent of the patients were seen by two senior cardiologists from two of Michigan's medical centers. A number of these patients had been seen previously by these consulting cardiologists.

Following the cardiac evaluation, each patient was placed into one of the following four preselected categories:

1 — Group I — children requiring immediate follow-up for treatment or further study

- 2 Group II children requiring follow-up for treatment or study within the next year
- 3 Group IV children requiring clinic observation and follow-up at stated intervals or at field clinics only
- 4 Discharge children who are discharged as presenting no evidence of heart disease or rheumatic fever

The referring physician and the State Health Department's Medical Coordinator responsible for the clinic area were sent reports of the cardiac evaluation.

RESULTS

There was a total of 722 patients. A number of these patients were seen more than once, but no effort was made to take an actual count of patient-visits. There were 378 males (52.4%) and 344 females (47.6%). The largest number of patients were initially seen in 1966 when 288 children (39.9%) visited the clinics (**Table 1**). Clinics were held in 16 cities. Their locations and attendance records are listed in (**Table 2**). Those serving the largest number of patients were held in Marquette

TABLE 6

CARDIAC DIAGNOSES OF PATIENTS ATTENDING
CARDIAC FIELD CLINICS

	Number	Percent
No Cardiac Disease Functional murmur	96 308	13.3 29.3 42.6
Congenital Heart Disease Rheumatic Fever and Rheumatic	203	28.2
Heart Disease	133	18.5
Disturbance of Conduction Valvu'ar heart disease —	11	1.5
etiology not spec.	10	1.4
Myocarditis - etiology not specified	1	0.1
Deferred	56	7.7
Total	722	100.0

TABLE 7
INCIDENCE OF VARIOUS CONGENITAL HEART DEFECTS

	Number	Percent within Con- genital Group
Ventricular Septal Defect	60	29.6
Ventricular Septal Defect with other	- 1	1
combinations (coarctation of aorta, patent foramen ovale, patent ductu	s }	71 35.0
arteriosus, aortic stenosis, right	\	
aortic arch)	11)	5.4)
Pulmonary stenosis	30	14.8
Patent ductus arteriosus	12	5.9
Tetralogy of Fallot	12	5.9
Aortic Stenosis	17	8.4
Atrial Septal defect	17	8.4
Coarctation of aorta	5	2.4
A. V. Communis	3	1.5
Mitral insufficiency	3	1.5
Other lesions	19	9.3
Type undetermined	14	6.9
Total	203	100.0

with 145 patients (20.1%), Saginaw with 106 (14.7%), and Monroe with 93 (12.9%).

AGE AND SEX OF CLINIC POPULATION

The age and sex distribution of the patients is shown in (Table 3). One hundred nineteen patients (16.5%) were in the 5-6 year age group, but there was a fairly even distribution of patients for most age ranges. There were 59 patients (8.2%) 17 years old or above, with few patients over nineteen years of age.

REASON FOR REFERRAL

The reason for referral was indicated for 716 patients (Table 4). The largest number of patients, 286 (39.9%), were referred because a heart murmur was present. The second largest group, 214 (29.9%), were seen because they had a history of rheumatic fever, rheumatic heart disease, joint pains, arthritis, or subcutaneous nodules. One hundred nine (15.2%) were seen for congenital heart disease. Another 107 had various signs and symptoms suggestive of heart disease.

INITIAL INDICATION OF HEART DISEASE

The time or circumstance of initial indication or suggestion of heart disease was known in 650 patients (Table 5). Two hundred fifty-nine (24.5%) were suspected of having heart disease during a routine physical examination. Ninetynine (15.3%) became heart disease suspects following an acute illness.

PHYSICAL EXAMINATION, ELECTROCARDIO-GRAPHIC AND CHEST X-RAY EXAMINATION

Four hundred sixty-seven patients (64.7%) had only systolic murmurs. Thirty-five (4.9%) had diastolic or both systolic and diastolic murmurs. One hundred fifty-eight (21.9%) had normal physical findings. Sixty-two patients (8.5%) had a variety of other findings, e.g., cyanosis, sinus tachycardia, and skin rash.

Six hundred sixty-eight patients had electrocardiographic examinations. Four hundred sixtyeight (70.1%) were normal. The single most frequent abnormal finding was a right bundle branch block found in 32 patients (4.8%). Sixty-one (9.0%) had left, right, or combined cardiac hypertrophy. The remaining 107 (16.1%) had p-wave abnormalities, minor conduction disturbances, left bundle branch blocks, etc.

Chest X-rays were taken in 685 patients. Five hundred five (73.7%) were normal. One hundred eight (15.5%) had cardiac enlargement. Twenty (2.9%) had pulmonary artery dilatation. The other 54 (7.9%) had a variety of other findings, such as right aortic arch, pulmonary infiltration, "abnormal chest."

TABLE 8
RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE

Diagnosis	Number	Percent
I. Rheumatic Heart Disease	63	47.4
rheumatic heart disease with mitral insufficiency rheumatic heart disease with aortic	33	24.8
insufficiency	10	7.5
rheumatic heart disease with both mitral and aortic insufficiency active rheumatic fever with residual	3	2.2
heart disease	2	1.5
rheumatic heart disease with mitral stenosis rheumatic heart disease with aortic	1	8.0
stenosis and aortic insufficiency with activity rheumatic fever — recurrent rheumatic fever (by history) with	1 1	8.0 8.0
possible residual heart disease	12	9.0
II. Acute Rheumatic Fever by History	70	52.6
acute rheumatic fever acute rheumatic fever with functional	33 I	24.8
murmur	20	15.0
possible acute rheumatic fever	17	12.8
Total	133	100.0

TABLE 9
RECOMMENDATIONS FOR PROPHYLAXIS

Rheumatic Fever and Rheumatic Heart Disease

	Т	otal Pop	ulation		
Re	commendation	No.	%	No.	%
1.	not recommended	506	70.1	25	18.5
2.	initiate prophylaxis	32	4.4	29	21.8
3.	continued monthly	66	9.1	55	41.4
4.	continued daily	5	0.7	4	3.0
5. 6.	sulfa continued daily erythromycin con-	8 112	1.1 4	97	51.1— 6.0
	tinued daily	1	0.1	1	0.7
7.	at time of tooth extraction or		,		, ,
	surgery	59	8.2	3	2.3
8.	discontinued	45	6.3	8	6.0
	Total	722	100.0	133	100.0

TABLE 10

FINAL DISPOSITION OF PATIENTS ATTENDING
CARDIAC FIELD CLINICS

Classification	Number	Percent	
Group I	69	9.6	
Group II	293	40.6	
Group IV	33	4.6	
Discharged	327	45.2	
Total	722	100.0	

CARDIAC DIAGNOSES

(Table 6) lists the cardiac diagnoses. No cardiac disease was found in 96 patients (13.3%). Two hundred twelve (29.3%) had a functional murmur.

Congenital heart disease was diagnosed in 203 (28.2%). Within this group (**Table 7**) ventricular septal defect alone or in combination with other

defects accounted for 71 diagnoses (35.0%). Nineteen cases were placed in the category of other, which consisted mainly of single diagnostic categories, such as single ventricle, dextrocardia, congenital mitral stenosis, and corrected transposition of the great vessels.

One hundred thirty-three (18.5%) of the 722 patients had either had rheumatic fever or else presently had rheumatic fever or rheumatic heart disease. (Table 8) gives a breakdown of the rheumatic fever diagnoses. Of the 133 rheumatic fever patients, 63 (47.4%) had rheumatic heart disease or active rheumatic fever. Seventy (52.6%) had a history of rheumatic fever or possible rheumatic fever. Sixty-eight were males (51.1%) and 65 were females (48.9%). This sex ratio is almost identical to that of the entire population. One hundred twelve (84.2%) of the rheumatic fever patients were in the 9-17 and above age range. Of the 63 rheumatic heart disease patients, 35 (56.6%) were female and 28 (44.4%) were male.

OTHER DIAGNOSES

In only 88 instances was an additional diagnosis entered into the records. There were nine diagnoses of obesity, seven of severe dental caries, five of rheumatoid arthritis, and five of Down's Syndrome. There was one instance in which the diagnosis of "questionable rheumatoid arthritis" was made along with a rheumatic fever diagnosis. The remainder of the other diagnoses represented single diagnostic categories, e.g., prematurity, multiple congenital abnormalities, and psychomotor retardation.

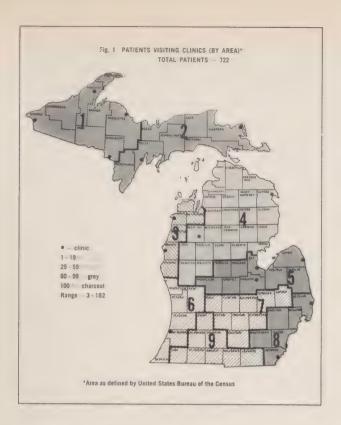
ANTI-BACTERIAL PROPHYLAXIS

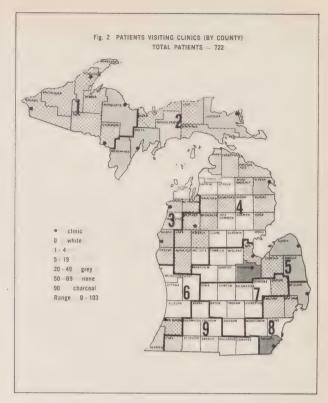
(Table 9) lists the recommendations for prophylaxis. One hundred twelve (15.4%) of the 722 patients had prophylaxis begun or continued; forty-five (6.3%) had prophylaxis discontinued. Within the rheumatic fever sub-group ninety-seven (72.9%) had prophylaxis begun or continued on a regular basis while eight (6.0%) had their prophylaxis discontinued.

HEALTH DEPARTMENT CLASSIFICATION AS HANDICAPPED CHILDREN

Ninety-nine (13.8%) of the children attending the field clinics were already known to the health department. Eighty-two of these patients had previously been classified as cardiac handicapped children; the other 17 were so classified after the cardiac evaluation. Another 15 (2.0%), previously unknown to the health department, were added to the Division of Services for Handicapped Children following the field clinic visit. Six hundred-eight patients (84.2%) were never classified as handicapped children.

Of the 133 rheumatic fever patients, 10 had previously been classified as cardiac handicapped





children in the above grouping; one new rheumatic patient was also classified as handicapped following the field clinic visit.

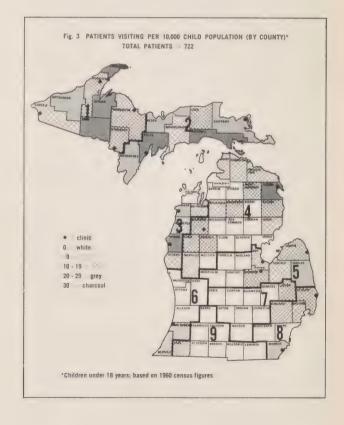
FINAL DISPOSITION AND FOLLOW-UP

(Table 10) lists the final disposition of patients seen in the clinics. Three hundred twenty-seven patients (45.2%) were discharged. Group II was the second largest group with 293 patients (40.6%). Approximately two-thirds of the rheumatic fever patients were placed in Group II.

Using the final disposition categories as a basis for follow-up, it is not known whether 151 patients (21.0%) have received follow-up as recommended; 311 (43.0%) were given no recommendations for follow-up; and the remaining 260 (36.0%) have either been followed-up in the field clinics or else the period for follow-up had not elapsed.

AREA OF RESIDENCE

Patients from 46 of Michigan's 83 counties have attended the clinics. (Figures 1, 2, and 3) are maps of Michigan, illustrating the number of patients attending the clinics by area, county, and child population. Michigan has been divided into nine areas by the United States Bureau of the Census.3 Clinics in Area 1 have had the largest attendance, followed by the clinics in Areas 8, 5, and 2. The greatest number of patients, however, were found to reside in Area 5, followed by Areas 8, 2, and 1. This indicates that patients did not necessarily remain within these conceptualized areas; but



rather, they crossed these boundaries to attend the nearest clinic.

The two single counties in which the greatest number of patients resided were Saginaw with 103 and Monroe with 92; but the counties of the upper pennisula, Areas 1 and 2, have had the largest number of patients per 100,000 child population. No clinics were held in Areas 7 or 9; however, a few patients from some counties in these areas did attend the clinics.

Of the 14 patients from Van Buren County attending the clinics, 11 were given rheumatic-fever-rheumatic heart disease diagnoses, while approximately one-quarter of those attending the Saginaw and Monroe clinics were given similar diagnoses.

DISCUSSION

Heart disease accounts for a significant part of the disease morbidity experienced in children and young adults. Most states have some form of organized medical care for children and young adults with heart disease. Many of these programs are located in health departments or Crippled Children's Agencies. Some take the form of a program for secondary prevention of rheumatice fever — "Bicillin program"; others are more elaborate and include consultation and hospitalization services for all forms of heart disease.

Over half of Michigan's population is located in the southern part of the state, and the remainder is scattered over a vast area.⁴ In many regions of the state there are few specialized services for children and young adults who have heart disease. Therefore, many patients have to travel great distances to obtain medical care. In an effort to provide better and more comprehensive services to these people, the cardiac field clinics were established.

Of the 722 patients studied, 378 (52.4%) were males and 343 (47.6%) were females.

APPROXIMATELY ONE-HALF of the patients were first suspected of having heart disease during a recent routine physical examination or during the pre-school (2-5 years) or school age period (6-10 years).

Almost 40% of all the patients were referred to the clinics without signs or symptoms of heart disease other than a murmur. Two hundred twelve (29.3%) of the 722 patients were actually found to have a functional murmur. Another 96 patients (13.3%) had no cardiac disease. Therefore, 308 patients (42.6%) had no cardiac disease or only a functional murmur.

It appears that the patients with no cardiac disease and those with a functional murmur represent two distinct populations. One hundred twenty-four (58.5%) of the 212 patients with a functional murmur were less than nine years old. On

the other hand, 63 (65.6%) of the 96 with no cardiac diagnosis were nine years old or above.

Approximately 15% of the patients were referred for follow-up of congenital heart disease. However, congenital heart disease was diagnosed in nearly 30% of the patients. Ventricular septal defect alone or in combination was the most frequent lesion and represented 35% of the 203 congenital heart disease cases, a percentage similar to that of other surveys.

Almost 30% of the patients were referred with a history of rheumatic fever, rheumatic heart disease, or ill-defined illnesses with joint pain or arthritis. However, 133 (18.5%) met the rheumatic fever diagnostic criteria of the examining cardiologists. The difficulty of diagnosing rheumatic fever has been demonstrated in practically every study undertaken on this subject. Sixty-three (47.4%) of these 133 patients had rheumatic heart disease. Thirty-five (56.6%) of these 63 patients were female and 28 (44.4%) were male. These figures are similar to those from the Toronto Heart Disease Registry.⁵

MANY OF THE patients presenting histories of rheumatic fever but without evidence of rheumatic heart disease had their rheumatic fever episodes several years prior to being seen in the clinics. Studies of patients with rheumatic heart disease reveal that heart disease may disappear in up to 25% of such patients.^{6, 7} This may apply to some of the field clinic patients who presented only histories of rheumatic fever.

Prophylaxis was recommended in 112 patients (15.4%) — initiated for 32 (4.4%) and continued for 80 (11%). It was discontinued for 45 patients (6.2%). These figures are of interest when the total number of persons receiving prophylaxis on the State Rheumatic Fever Secondary Prevention Program is taken into consideration. With less than a 2% difference between those who had the drugs discontinued and those who were started on prophylaxis, it may be inferred that the number of patients on the Michigan prophylaxis program would probably remain unchanged if medication were requested and provided as medically indicated.

Of the 133 patients with rheumatic fever or rheumatic heart disease, 68 (51.1%) were already receiving regular prophylaxis; and 29 (21.8%) were recommended to begin prophylaxis. Thus, 97 (72.9%) in the rheumatic patient population required prophylaxis on a regular basis. The other 15 patients on prophylaxis were not diagnosed as rheumatic.

THE OVERWHELMING MAJORITY (84%) of the 722 patients were never classified as handicapped children by the State Health Department, inasmuch as this involves first, seeking care; second, the availability of funds; and then satisfying

certain residential and economic requirements for the State Program. Thirty-two patients (4.5%), however, were added to the State Program as cardiac handicapped children following their field clinic visits. Therefore, these clinics do serve as a source of case finding for the State Program.

Follow-up of patients after being seen at the field clinics is more difficult to evaluate. The follow-up of those patients who were classified as handicapped children and who receive their care under the auspices of the State Health Department is virtually complete. In the other and larger group (84%), the patients were referred back to their physicians who may, or may not, elect to follow through with the recommendations of the consultants. These physicians may provide their own follow-up, make arrangements for follow-up, or send their patients back to the field clinics for follow-up. In considering these options, many preferred to send them to the field clinics for follow-up.

To a large extent the clinic locations and the availability of services determined the degree to which these services were utilized. It was the initial intent of the public health officials that clinics should be located away from medical centers in areas where special services are more difficult to obtain. Such locations for the clinics have enhanced the use of their services; most areas of the Upper Penninsula, where there are fewer specialized facilities, were, in fact, well represented within the patient population.

When further considering the cardiac field clinics, it is often questioned whether clinics should be provided in areas that are not presently covered by the field clinics and that ostensibly have adequate hospital facilities. A review of rheumatic fever data from some of the larger metropolitan health departments suggests that several pilot clinics in these urban centers may be warranted.

SUMMARY

In a study of 722 patients attending cardiac field clinics operated by the State Health Department, approximately 30% of the patients had functional

murmurs; 30% had congenital heart disease; and 18.5% had rheumatic fever. Almost half of those with rheumatic fever had heart disease. Ventricular septal defect was the most frequent congenital defect.

The survey further documents the need for and the usefulness of the cardiac field clinics in providing high quality, comprehensive, medical care to children and young adults.

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MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FOUR-WEEK PERIOD ENDING JUNE 27, 1969

	1969 This 4-Week Period	1968 Same 4-Week Period	1969 Total To Above Date	1968 Total Same Date	Total Cases for 1968
Rubella	712	213	3340	1285	1953
Measles	44	31	185	228	352
Whooping Cough	7	32	61	236	429
Diphtheria			Makes 14	property	-
Mumps	497	247	3600	12698	14655
Scarlet Fever &					
Strep Sore Throat	487	487	5785	6469	10101
Tetanus	1	1	2	2	5
Poliomyelitis (paralytic)	tunes	-	_	_	3
Hepatitis	242	238	1568	1010	2356
Salmonellosis					
(Other than T. typhi)	49	65	227	328	614
Typhoid Fever (S. typhi)	1		4		1
Shigellosis	16	17	147	106	346
Aseptic Meningitis	2	1	37	25	265
Encephalitis	8	4	47	48	114
Meningococcic Meningitis	11	11	82	57	94
H. Influenzal Meningitis	3	5	27	28	64
Tuberculosis	148	214	1149	1425	2647
Syphilis	295	326	2207	2784	5351
Gonorrhea	1345	1215	8567	8280	18153

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director Michigan Department of Public Health

CARDIAC VIEWS:

Treatment of Shock Following Myocardial Infarction

BY JAY N. COHN, M.D. WASHINGTON, D.C.

While newer refinements in patient monitoring and management have significantly reduced the mortality from acute myocardial infarction, the occurrence of shock still carries a grave prognosis. Once shock develops the survival of the patient is entirely dependent on the perception, attentiveness and judgement of his physician.

Shock is characterized by a critical reduction in tissue perfusion. Inadequacy of blood flow impairs organ function and disrupts the integrity of normal metabolic pathways. If shock is not promptly corrected, the flow deficiency leads to organ damage, metabolic acidosis and a vicious circle resulting in progressive circulatory deterioration and death. The sooner the syndrome can be recognized the more likely is therapy to be effective.

The need for prompt recognition of shock must not, however, be satisfied at the expense of "overdiagnosis." It is in this initial evaluation that the physician's perceptiveness is critical. He must be able to recognize the difference between the mildly hypotensive patient who is adequately perfusing his tissues (and needs no immediate treatment) and the patient who is in the incipient stages of shock and requires prompt therapy to restore peripheral blood flow.

Diagnosis of Shock

In considering the diagnosis of shock, attention should be given to the following signs:

- 1. Skin temperature. Warm skin indicates adequate cutaneous blood flow and usually a fairly well maintained cardiac output. Cool, clammy skin indicates sympathoadrenal discharge, a sign of reflex vasoconstriction in response to a fall in cardiac output.
- 2. Peripheral pulses. Thready or absent brachial and radial pulses indicate either severe hypo-

tension or more often intense vasoconstriction. In either case urgent treatment is indicated. Femoral artery pulsation will be very weak if the patient is hypotensive but the pulsations are bounding in the presence of peripheral vasoconstriction.

- 3. Auscultatory blood pressure. This is not a reliable guide to intra-arterial pressure in shock. A low cuff pressure has the same significance as weak upper extremity pulses. However, an absent auscultatory pressure usually indicates inadequate blood flow and the need for treatment.
- 4. Mentation. If the patient is alert and responsive cerebral blood flow is probably adequate. Agitation, confusion or somnolence are signs of deficient cerebral blood flow and usually are associated with a fall in arterial pressure.
- 5. Urine output. Urine flow less than 20 ml/hour with a low urine sodium concentration is evidence of inadequate renal blood flow which if not corrected, can lead to tubular necrosis.
- 6. Cardiac function. Persistent or recurrent chest pain or arrhythmias in the presence of other signs of hypotension may be accepted as presumptive evidence of functional impairment of coronary blood flow.
- 7. Acidosis. Low arterial blood pH and elevated blood lactate mean reduced tissue oxygenation. Arterial blood gas and pH studies are invaluable in the management of patients in shock.

The presence of one or more of the above signs of inadequate tissue blood flow in a patient with an acute myocardial infarction is presumptive evidence of shock. Mild hypotension in the absence of any of these signs should not be diagnosed or treated as "shock."

Patient's Hemodynamic Status

When the diagnosis of shock has been made, several questions regarding the hemodynamic status of the patient should be answered before definitive treatment can be instituted:

1. Is the patient severely hypotensive? Hypo-

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- tension is an immediate threat to life because of the associated impairment in cerebral and coronary blood flow. Since the cuff pressure may be low even though arterial pressure is normal, the strength of femoral arterial pulsations often is a more reliable guide to blood pressure. In some patients direct recording of arterial pressure may be necessary.
- 2. Is blood volume adequate? Some patients become hypovolemic in the hours following an acute myocardial infarction and the reduction in plasma volume may then become an important factor in the genesis of shock. The central venous pressure (CVP) is a vital guide to the adequacy of circulating volume and should be monitored in all patients with shock. This can be accomplished by threading a catheter through a needle in the brachial, femoral or subclavian vein and advancing it into the thorax. A low CVP (less than 6 cm H₂O with the zero level at the mid-chest) is an indication for a trial of volume expansion. In myocardial infarction the left ventricle often is in failure while CVP is normal. Therefore, volume expansion should be carried out cautiously. A rise in CVP of more than 2 cm H₂O during infusion of dextran, saline or other fluid indicates that volume has been adequately restored. If shock is not corrected by volume expansion the presence of significant left ventricular failure can be assumed.
- 3. Is cardiac function severely impaired? If peripheral blood flow is markedly reduced and the CVP is high, then myocardial failure is obviously an important factor in the shock. Heart rate is not a very useful index of cardiac function. Indicator dilution cardiac output data are of value in the evaluation of myocardial function in selected cases.
- 4. What is the status of the peripheral vessels? Is there evidence of intense sympathetic discharge? This usually is manifested by cutaneous vasoconstriction and indicates renal vasoconstriction as well. In early stages of shock peripheral constriction may support fairly normal arterial pressure despite progressive tissue hypoperfusion and lactic acidosis.

The purpose of therapy in shock is to restore adequate organ perfusion. Effective therapy must be based not only on an understanding of the physiological disturbance in the individual patient but also on a thorough understanding of the pharmacological action of the useful drugs.

Possible Useful Drugs

The following drugs may be valuable in certain patients with cardiogenic shock:

- 1. Isoproterenol. This is a catecholamine with pure beta adrenergic activity; that is, it stimulates the heart and dilates peripheral vessels. It is probably the agent of choice when impairment of cardiac function has led to severe reduction in cardiac output, especially when reflex vasoconstriction is present. Isoproterenol 1 or 2 mg should be diluted in 500 ml 5% dextrose in water and the rate of infusion gradually increased until the signs of shock are corrected or cardiac rhythm disturbance limits further administration. In some cases the concentration of isoproterenol must be increased as much as 2 mg/100 ml to obtain a satisfactory effect. Lidocaine may be effective in controlling ventricular irritability during isoproterenol infusion. In some hypotensive patients isoproterenol will not significantly increase arterial pressure and cerebral and coronary perfusion are not improved. In this situation a vaso-constrictorinotropic agent may be necessary.
- 2. Levarterenal (Norepinephrine) or metaraminal. These drugs have an alpha adrenergic effect (vasoconstrictor) on peripheral vessels combined with myocardial stimulating properties. Because these drugs may reduce renal and splanchnic blood flow they should be used only when isoproterenol is ineffective. The infusion rate should be the smallest amount necessary to increase systolic arterial pressure over 100 mm Hg.
- 3. Digitalis. The cardiac glycosides have inotropic effects less potent than the catecholamines. They also have vasoconstrictive properties when used intravenously. It is probably best to treat cardiogenic shock acutely with the adrenergic inotropic drugs above and to administer digitalis orally for its more sustained effect.
- 4. Atropine. If shock is associated with sinus bradycardia, 1 mg atropine intravenously may be effective in restoring heart rate and blood flow. Drugs, such as atropine and isoproterenol, which result in an increase in atrial rate must be used cautiously in the presence of atrioventricular block. Under these circumstances, an increase in atrial rate may result in a decrease in ventricular rate.
- 5. Furosemide. This potent diuretic can help establish urine output in the oliguric patient. After shock has been treated with the vasoactive compounds above a diuretic response to intravenous infusion of 200 mg of furosemide indicates that renal perfusion is adequate. If oliguria persists, however, more aggressive attempts to improve blood flow are necessary.
- 6. Sodium Bicarbonate. If the arterial pH is less than 7.35 sodium bicarbonate should be administered in amounts adequate to restore

- pH to above that level. Treatment should be initiated with 40-100 meg sodium bicarbonate and further alkali therapy based on arterial blood pH measurements.
- 7. Ventricular Pacing. If shock and marked bradycardia co-exist, increase in ventricular rate via catheter electrode pacing is often of great clinical benefit.

Newer pharmacological approaches such as the use of sympathetic blocking agents and other inotropic drugs, such as dopamine and glucagon, are still in the experimental stage.

Effectively Managing Shock

Effective management of shock requires not only initiation of the correct therapy in the correct amounts, but also close continuous monitoring of cardiovascular function. Adrenergic drugs should be weaned and discontinued as soon as possible. Blood volume may be inadequate after cardiac function is improved, and a falling CVP may be an indication for administration of dextran, even in patients who have manifested heart failure only a few hours before. If rhythm disturbances persist electrical pacing through a transvenous pacemaker may help improve peripheral blood flow.

It is clear that intelligent use of the means currently available can be effective in salvaging many patients who would otherwise succumb to cardiogenic shock. In others, however, the impairment in cardiac performance is so severe that medical therapy is ineffective. In this selected group of patients mechanical means of temporary circulatory support may eventually become an important adjunct to management.



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A patient with diabetes mellitus and rhino-orbital-cerebral phycomycosis who recovered following amphotericin-B therapy is presented. Culture of a palatal lesion revealed the causative organism. Rhizopus nigricans. An unusually long interval (38 days) elapsed between the onset of symptoms and diagnosis. A carotid arteriogram demonstrating a "cork-screw" filling-defect of fungal origin in the right internal carotid artery is a unique finding not previously reported. Extremely important is early diagnosis secondary to a high index of suspicion in the classical circumstances with rapid instituton of therapy.

Rhino-Orbital-Cerebral Phycomycosis

BY C. KOHLER CHAMPION, M.D. U.S. ARMY, GERMANY TOM M. JOHNSON, M.D. ANN ARBOR

The rhino-orbital-cerebral form of phycomycosis, although rare, presents in a classic and easily recognized symptom complex.

It occurs in a host with lowered resistance (1) secondary to infection by the common "bread" fungus which belongs to the class Phycomycetes. The most frequently cultured genus of this class is the Rhizopus.

We wish to report successful treatment of a patient with amphotericin-B administered systemically and by local sinus irrigation. In retrospect the patient presented with classical findings; however, diagnosis was not established until biopsy of a palatal ulcer and culture of this material demonstrated the causative organism. The slowly progressive initial course in this patient with phycomycosis was unusual. This patient is the seventeenth case reported cured.

A carotid arteriogram revealed a "corkscrew" filling-defect of fungal origin in the right internal carotid artery. This unique finding has not been previously reported during the active clinical phase and is important in the diagnosis and understanding of the pathophysiology of this condition. The importance of early recognition and treatment of this disease is reviewed.

CASE PRESENTATION

M.B. (U.H. #022600) a 39-year-old white female with diabetes mellitus was admitted to the University Hospital Oct. 6, 1964, with right facial

Doctor Champion is a captain with the U.S. Army, while Doctor Johnson is now assistant professor of medicine with the Michigan State University College of Human Medicine.

pain and earache. She was transferred from an outside hospital where she had been admitted 10 days previously, febrile, with tenderness and swelling in the right facial area. Initial treatment with insulin, intravenous fluids, antibiotics of unknown type, and analgesics was unsuccessful and because of increasing pain and difficulty with control of her diabetes, she was transferred to University Hospital. It was noted that she had been a poorly controlled diabetic for 14 years with multiple hospital admissions for treatment of insulin reactions and diabetic acidosis. She had undergone a 70% gastric resection for gastric ulcer in 1963. The patient gave a long history of "sinus" infections and frequent colds which had been treated with multiple antibiotics.

Physical examination revealed swelling of the eyelids and tenderness over the right maxillary and ethmoidal sinuses, while the nasal mucosa on the right was edematous and injected. There was blood-streaked purulent discharge from the right nostril. She was edentulous, and no oral lesions were initially noted. The neurological examination was normal. X-rays revealed mucosal thickening and clouding of the right maxillary and ethmoidal sinuses. Her diabetes was successfully controlled, and following a ten-day course of penicillin the patient improved and was discharged. One week later on Oct. 21, 1964, she was re-admitted to her local hospital at which time a palatal ulcer, bleeding from the right nostril, and weakness of the left upper and lower extremities were noted.

On Oct. 31, 1964, she was again transferred to the University Hospital at which time physical examination revealed a disoriented white female with a right internal and external ophthalmoplegia, tenderness over the right maxillary sinus, and a punched-out 1 cm. ulcer in the right hard palate (Fig. 1) which could be probed to a depth of 1 cm. A left flaccid hemiparesis and a left central facial paralysis became evident by the third hospital day. Lumbar puncture and brain scan using Hg¹⁹⁷ were normal. Laboratory data: WBC on admission was 16,600 with 89% PMN'S; one week later the WBC fell to 6,000; a protein electrophoresis was normal.

The diabetes was again controlled by intensive use of intravenous fluids and insulin. Sinus X-rays demonstrated a progressive change in the pansinusitis consisting of increased mucosal thickening and a suggestion of destruction of the medial wall of the right maxillary sinus which was verified with laminography (Fig. 2). A right brachial arteriogram on Nov. 2 revealed flow stagnation in the internal carotid artery. The following day a right carotid arteriogram (Fig. 3) showed a serpiginous filling-defect in the right internal carotid.

Biopsy and scrapings of the palatal ulcer demonstrated on microscopic examination thin-walled, irregular, non-septate hyphae, typical of phycomycetes. Culture of these scrapings was positive 12 days later for Rhizopus nigricans. Following the

biopsy, the patient was begun on amphotericin-B which was increased progressively to 50 mgm. intravenously daily until a total dose of 2 gms. was administered. Amphotericin-B in a concentration of 1 mgm. per cc. of 5% dextrose and water was used for irrigation of the maxillary sinus for only two days. She was discharged on the 88th hospital day.

At discharge there was a residual right ophthalmoplegia, left central facial paralysis, and flaccid left hemiparesis. The patient died two years later in an outside hospital during treatment for diabetic keto-acidosis. There was no clinical evidence at any time of recurrent Rhizopus infection.

DISCUSSION

Several excellent and thorough reviews of the problem of phycomycosis^{1,2} have recently appeared in the literature. This patient demonstrated the typical history of progression of the disease when left untreated as well as several factors unique to this case.

A diabetic patient with keto-acidosis who pre-

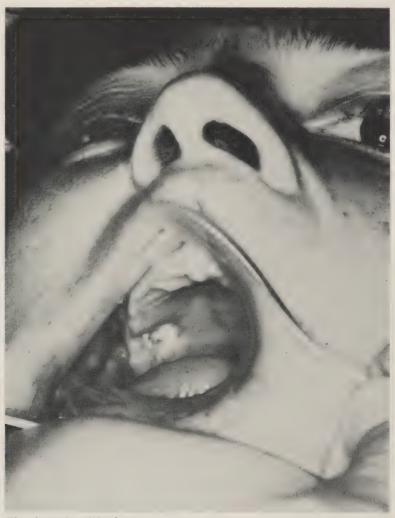


Fig. 1: Palatal lesion

sents with findings of (1) paranasal sinusitis with bony erosion; (2) ophthalmoplegia, proptosis, and ocular cellulitis; and (3) central nervous system signs secondary to occlusion of the carotid artery should be considered to have the mycotic disease, phycomycosis, in the rhino-orbital-cerebral form. Because of the malignant nature of the disorder, treatment should be initiated as soon as clinically justified.² Major diseases to be distinguished from rhino-cerebral phycomycosis include septic cavernous sinus thrombosis and septic or neoplastic local disease of the sinus or orbit.3

The bloody discharge from the nose was a diagnostic clue which, according to Smith and Kirschner,4 is an important clinical sign. The infection starts as a sinusitis with later local extension to and through the palate as well as to the eye, producing a cellulitis, lid proptosis, internal and external ophthalmoplegia. Subsequent extension to the carotid artery produces occlusive vasculitis and ischemic neurologic signs. The eye signs are produced by both local involvement of the orbit and central nervous system involvement.

This case presented several unique clinical and radiographic findings as well as several unusual features not previously emphasized. It has been found to be one of the most acutely fatal fungal diseases of man. However, this patient's symptoms began on or about September 21, 1964, with the diagnosis being made after severe neurological impairment had set in 35 days later. This protracted course is unusual. The majority of reported cases terminated fatally in less than 10 days1 not allowing time for diagnostic procedures or initiation of adequate antifungal therapy.

A cure was not reported in the American litera-

ture prior to 1954 following which five well-substantiated cures were reported.⁵⁻⁸ These cases were not treated with amphotericin-B. Since that time there have been 11 cases reported^{1,2,10-16} to have been cured by the use of amphotericin-B, supporting the assumption that the agent is therapeutically effective in this condition.2 The number of "clinical cures" compared to the total number of cases treated with amphotericin-B has not been established.

Excluding the present case, 16 patients^{1,2,5-16} had orbital-sinus involvement, and 111,2,5,7,8,11,12,14-16 had definite central nervous system involvement. Two of these patients^{4,9} had no residual impairment; in others, ophthalmoplegia, facial paralysis, or hemiparesis were frequently noted. Culture of the offending agent, usually one of the species of Rhizopus, has been positive in eight cases.^{2,5-7,11-13,15} In the 16 patients reported to date, diabetes mellitus was present in all but one,14 one of which was non-ketotic.16

Our patient was treated with a total intravenous dose of 2 gms. of amphotericin-B; in other reported cases1,2,15 2 to 4 gms. has been recommended as the optimum total dose. The use of amphotericin-B is primarily systemic. Several reports^{2,11,12} stress the importance of irrigation of the sinuses, although local irrigation has been questioned16 because of local necrosis attributed to this drug. Rigid diabetic control, as well as local or radical surgical excision of the involved tissue has been stressed by several authors. 10-12,14

The diagnosis of rhino-orbital-cerebral phycomycosis may be suspected by performing proper roentgenographic studies. Paranasal mucosal membrane thickening is often seen and must be dis-



Fig. 2: Laminogram showing clouding of the right ethmoidal sinus and medial wall destruction of the right maxillary sinus.



Fig. 3: Right carotid arteriogram demonstrating the "cork-screw" filling-defect in the right internal carotid artery.

tinguished from chronic sinusitis. Certain differentiating features of phycomycosis have been stressed:17 1) nodular thickening of the soft tissues lining paranasal sinuses; 2) local destruction of the bony walls of one or more of the sinuses; 3) absence of fluid levels in erect roentgenograms. By contrast, presence of bone destruction in chronic sinusitis is usually associated with sclerosis. Arteriographic studies may be helpful but have been reported in a minority of cases. Occlusion of the left ophthalmic artery16 and complete occlusion of the internal carotid artery at its origin¹⁵ have been reported. However, the latter study was done 13 months after the patient had completed treatment for phycomycosis. In this case transient left hemiparesis may have been due to progressive arteriosclerosis in this patient with diabetes mellitus rather than secondary to fungal arteritis. Onset of a left hemiparesis in our patient led to a right carotid arteriogram during the rapidly progressive phase. This study demonstrated 'cork-screw' thrombus of probable fungal origin in typical location in the internal carotid artery. Such a lesion during the acute phase of this illness has not been previously reported. It is well established¹ that this fungus has a predilection for blood vessel wall and produces tissue necrosis and thrombosis which leads to the classical signs and symptoms. The usual location of the carotid artery involvement has been on the left¹⁸ although in our patient the lesion was demonstrated on the right.

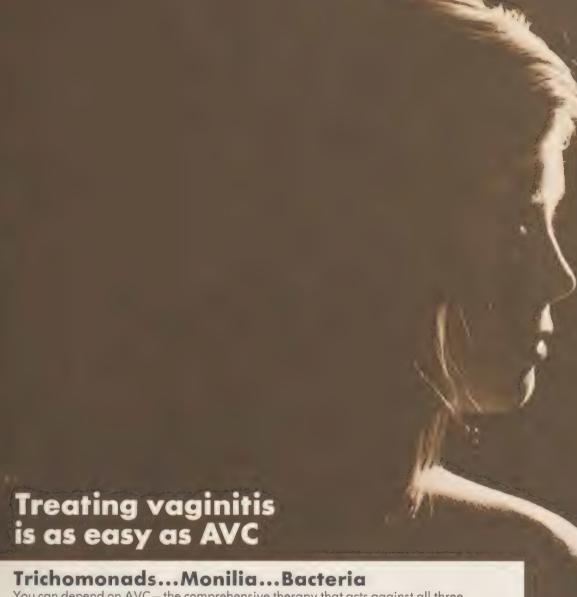
ACKNOWLEDGEMENTS

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You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem recent studies report increased incidence, attributed in part to the use of oral contraceptives, 1-4 broad-spectrum antibiotics 5-9 and prolonged use of corticosteroids.7 recent evidence establishes high rate of microbiological and clinical cure with AVC.9-11

Comprehensive — Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfon-

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue

treatment.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: Cream — Four-ounce tube with or without applicator. Suppositories — Box of 12 with applicator.

applicator. References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec.

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THE NATIONAL DRUG COMPANY PHILADELPHIA, PENNSYLVANIA 19144

CREAM (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

SUPPOSITORIES (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.014 Gm.)



Proteolytic enzyme therapy specifically indicated for the rapid resolution of inflammation and edema as adjunctive therapy in accidental and surgical trauma.

1 tablet q.i.d. provides recommended therapeutic dose at lower cost.



Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, litching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminura and hematuria, increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be

Dosage: One tablet q.l.d.

Description: ORENZYME BITABS offers the therapeutic effects of trypsin in an oral form as adjunctive therapy for the rapid resolution of inflammation and edema. ORENZYME BITABS is convenient to use, promotes patient cooperation and is ideally suited for maintenance therapy following parenteral trypsin Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:

Accidental Trauma

☐ Postoperative Tissue Reactions

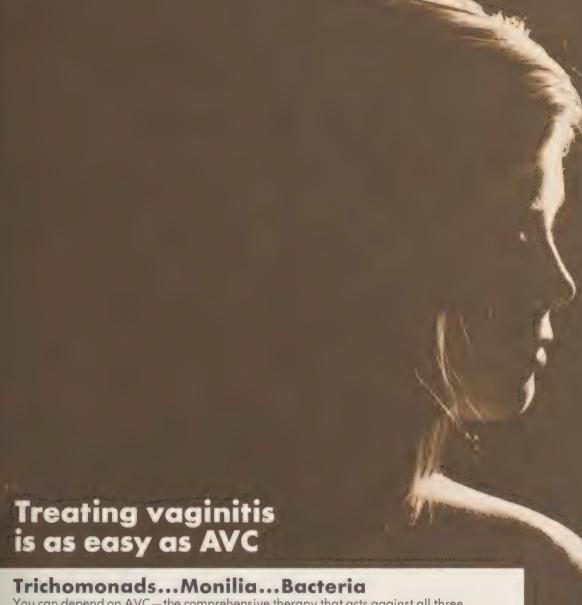
Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.



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You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

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Dosage: One tablet q.l.d



THE NATIONAL DRUG COMPANY DIVISION OF RICHARDSON-MERRELL INC

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Many Michigan doctors take time to serve on the boards of the health and welfare agencies sponsored by the Michigan United Fund. Representative of them all are several pictured here and on the following pages. Appreciation is extended to the Michigan United Fund for supplying the photos taken at the recent annual budget meeting.

MSMS's HIGHLY ACCLAIMED member and 1968 Physician of the Year, Marjorie Peebles-Meyers, M.D., Detroit, stands to discuss a point at a meeting of the Michigan Diabetes Association of which she is vice president. President, Fred W. Whitehouse, M.D., Detroit, is at right.



Dean A. LeSher, M.D., Ph.D., Detroit, left, and John Peirce, M.D., Grand Rapids, right, flank Michigan Kidney Foundation President Charles Monahan, Grosse Pointe, in a board meeting discussion.

PLAYING A PART in the board meeting of the Michigan Society for Mental Health is Jack M. Stack, M.D., Alma, right center, a board member. Others from left, are Robert M. Reames, Lansing, state board member, and Paul D. Bagwell, Detroit, president of the MSMH.



UNITED FUND ORGANIZATIONS, Cont.

ADDRESSING THE MEETING of the board of the Michigan chapter, Arthritis Foundation, is state foundation medical director James J. Lightbody, M.D., Detroit, also MSMS president. John W. Sigler, M.D., Detroit, state foundation presidentelect, is on Doctor Lightbody's right, while H. J. McLaurin, Dearborn, chairman of the board, flanks the MSMS president on the left.





FRIENDLY CONVERSATION PRECEDES the meeting of the United Cerebral Palsy Association as board members Richard Pomeroy, M.D., Lansing, left, and John Poort, Jr., Muskegon, vice president, meet informally.

PRESIDENT-ELECT AND PRESIDENT of the Michigan Heart Association are Edward W. Green, M.D., left, Lansing, and Michael C. Kozonis, M.D., Pontiac, who are among the many physicians who take important parts in Michigan United Fund agencies.





GLADSTONE PHYSICIAN AND president of the Michigan Association for Retarded Children is George D. Maniaci, M.D., right, who confers with Roscoe W. Scott, Lansing, executive director.

UNITED FUND ORGANIZATIONS, Cont.

REPORTS PROVIDE LIVELY reading for Kenny-Michigan Rehabilitation Foundation agency representatives, from left, James W. Rae, M.D., Ann Arbor; J. P. Schaupner, Southfield, chairman of the board; Edward Derbabian, Detroit, and John W. Moses, M.D., Detroit, vice president and president of the medical staff for the foundation.





HEALTH CAREER CLUB members from several Michigan cities discussed their club activities during an afternoon session of the 1969 Michigan Health Congress held May 21 at Towsley Center for Continuing Medical Education, The University of Michigan. Among the young speakers were Dwight Murchison and Freda Crumpton, from Detroit's Martin Luther King High School Medical Careers Club.

MICHIGAN HEALTH CONGRESS PHOTO HIGHLIGHTS



DURING THE RECENT Michigan Health Congress in Ann Arbor, Lionel F. Swan, M.D., Detroit, left, and Harry A. Towsley, M.D., Ann Arbor, found time for informal talk. Doctor Swan was one of three morning panelists at the all-day meeting, and Doctor Towsley, immediate past president of the Michigan Health Council, was general chairman.



THE DETROIT SKYLINE backs William L. Simpson, M.D., left, and Brock E. Brush, M.D., as they discuss the recent Detroit Healthorama. The long tent (in photo just above Doctor Brush's arm) housed medical crews offering free health examinations in the summer campaign. The effort to help inner city residents arrest or cure heart disease, cancer, cirrhosis of the liver and tuberculosis attracted 5,000 Detroit residents, Doctor Simpson, Michigan Cancer Foundation vice president, was Healthorama medical director: Doctor Brush is trustee board chairman for MCF, one of the 25 Detroit-area Torch Drive agencies which sponsored the Healthorama.

FACTS ON ARTHRITIS were presented at a recent meeting of the Northern Michigan Medical Society by Jerry Walsh, second from left, director of special services for the National Arthritis Foundation, New York City. Mr. Walsh made the northern visit while in Michigan for the recent Arthritis Forum co-sponsored by MSMS, the Wayne County Medical Society, Michigan Arthritis Foundation and the Detroit News. With Mr. Walsh, from left, are Rick Smith, local Arthritis Foundation director; Robert Martin, M.D., NMMS president, and Victor Tsalof, M.D., NMMS program director.



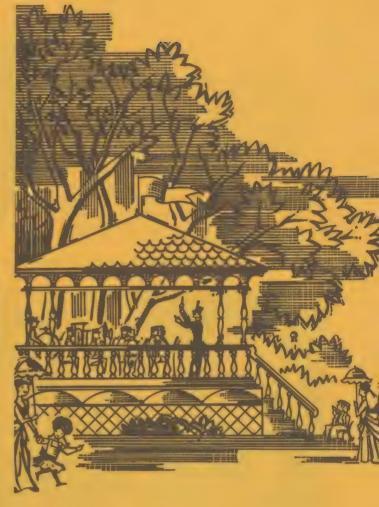
AMONG MIDWESTERNERS ATTENDING the annual Breakfast concluding the AMA/AMPAC Congressional Workshop late in the spring in Washington, D.C., were these five. From left are Louis R. Zako, M.D., Allen Park; James Imboden, Chicago, Field Representative, AMA; James J. Lightbody, M.D., MSMS president; House Minority Leader Gerald Ford of Grand Rapids, and Thomas R. Berglund, M.D., Kalamazoo. The workshop featured talks by AMA executives and congressmen on a variety of governmental and health projects.



Just 10 years ago this summer Conrad Lam, M.D., chief of thoracic surgery at Henry Ford Hospital, Detroit, was the only person to appear at an organizational meeting of the Franklin Village Band, advertised in the BIR-MINGHAM ECCENTRIC. Now the band numbers 30 Franklin resident volunteers and Doctor Lam is conductor. Organized to recall the days when all small towns had their own bands, the group has been called "The Band That's All Brass," because a large number of its members are business executives. It is an integral part of all community activities and has been joined by jazz drummer Gene Krupa in concert on the Franklin Village green, led a parade honoring famous Franklin resident Al Kaline, and this summer will play in the stadiums of the Detroit Lions and Tigers.

THE BASS DRUMMER in the Franklin Village Band is Mrs. Conrad Lam, far left, who has symphonic percussion experience.





OLDTIME BAND SOUNDS entertain the crowd at the recent Annual Franklin Strawberry-Ice Cream Festival as Conrad Lam, M.D., leads "America's No. 1 Community Brass Band."



'THE BLOB' AND its creator: Research orthotist Richard Koch of the University of Michigan Hospital handles a new polyvinyl gelatin which promises to aid bedfast patients, those with artificial legs and arms and maybe even traveling salesmen and athletes. The gel, created at U-M, has the consistency of human flesh and is designed to act as a cushion for persons who must sit or lie in one position for long periods of time.



Blue Shield Installs New Equipment

SOPHISTICATED NEW EQUIPMENT designed to make record-keeping for Michigan's doctors faster and more accurate has been added to Michigan Blue Shield's Doctors Registrar department. Called "Miracode," for Microfilm Retrieval Access Code, it contains the information formerly held in 20 square feet of filing cabinets. Leila George, left, operates a reader-printer and its accompanying retrieval keyboard, observed by Prince E. Holliday, left, manager of the Physician and Provider Services Department, and Clay Shumard, supervisor of Doctors Registrar.



MORE NEW EQUIPMENT installed by Blue Shield includes the keypunching and filming apparatus of the Miracode operations. Key figures in co-ordinating the improved doctor record service include Sharon Virga, staff assistant in Physician Provider services, keypuncher Janet Stitz and Michael J. Williams, Miracode input filmer.



Dissection of a Squid Giant Synapse.



Counting colonies of hamster tumor cells.

Continuing contributions by Michigan physicians to the AMA's Educational Research Fund make possible a variety of projects at the AMA's Institute for Biomedical Research. The four-year-old institute, at AMA headquarters, involves physicians throughout the country in the creation of knowledge that underlies all medical practices and helps them maintain research that individually they would not have the time and resources to support. Plans are afoot for a new institute building adjacent to the University of Chicago's Science and Medical Centers. On this page are photographs of some of the Biomedical Institute's projects.



Emptying the distillate from a vacuum glass still.

AS GUESTS WATCH, John Wick, R.N., MNA president, prepares to cut the ribbon at dedication ceremonies of the Michigan Nurses Association's new headquarters at 120 Spartan Avenue, East Lansing. The MNA, which previously had downtown Lansing headquarters, moved into its large, new building in May. Main speaker for the dedication was Miss Patricia Walsh, R.N., Ann Arbor, front right, former MNA president, now director of nursing with the Washtenaw County Health Department.



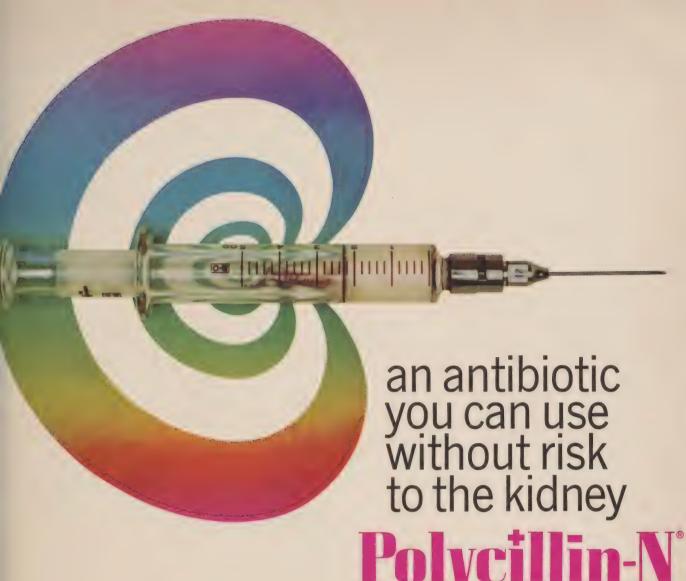


EARLY AND RECENT copies of the Journal of the Michigan State Medical Society, now Michigan Medicine, are compared by Birmingham pediatrician Harold R. Roehm, M.D., in his booklined office. Doctor Roehm, who is 72, has collected and bound copies of MSMS's Journal for 40 years. His extensive library also includes bound copies of the Journal of the American Medical Association dating from 1925.



MSU Begins Life Sciences Building

CLODS OF EARTH fly as the first spades of dirt are removed in preparation for the building of the Michigan State University Life Sciences Building. Manning the shovels, from left, are Rep. William R. Copeland, chairman of the Michigan House Appropriations Committee; Don Stevens, chairman, MSU Board of Trustees; MSU Acting President Walter Adams and Sen. Charles O. Zollar, chairman of the Senate Appropriations Committee. Ground was broken June 23, for the building, which will enable MSU to expand its entering medical class from 30 to 64 students.



Polycillin-N° (sodium ampicillin)

the penicillin you use like a broad-spectrum antibiotic

PRESCRIBING INFORMATION. 11-1/2/69. For complete information consult Official Package Circular.

Indications: Infections due to susceptible strains of Gramnegative bacteria (including Shigellae, S. typhosa and other Salmonellae, E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae and N. meningitidis) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci)

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-produc-

ing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets. Usual Dosage: Adults-250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children-50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis-150-200 mg./ Kg./ day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days. Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./ 5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable-for I.M./I.V. use-vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops-100 mg./ml. in 20 ml. A.H.F.S. Category 8:12.16

BRISTOL

BRISTOL LABORATORIES Division of Bristol-Myers Company Syracuse, New York 13201



Indications: For the treatment of trichomoniasis in both male and female patients and the sexual part-ners of patients with a recurrence of the infection provided trichomonads have been demonstrated by

wet smear or culture.
Contraindications: Evidence of or a history of blood

of pregnancy. Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers; it is not known whether this can be injurious to the newborn. Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is

necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treat-

organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of Monilia, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weak-

Flagyl brand of metronidazole

simplifies vaginitis therapy

The effectiveness of Flagyl in Trichomonas vaginalis vaginitis has been so constant that use of less effective agents would seem to invite unnecessary failures. • The simplicity, completeness and persistence of cures with Flagyl qualify it as the logical first therapeutic choice in trichomonal infections.

simple

Ten-day treatment with Flagyl oral tablets has replaced a multitude of untidy douches, powders, creams and jellies.

complete

Flagyl is the only medication available that is able to reach all the as reservoirs of reinfection in male trichomonas carriers.

lasting

Flagyl eradicates resistant, deep-seated invasions of Trichomonas vaginalis and consistently produces cure rates above 90 per cent and often as high as 100 per cent in large series of patients. When the

ness," urticaria, flushing, dryness of the mouth, ness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: In the Female. One

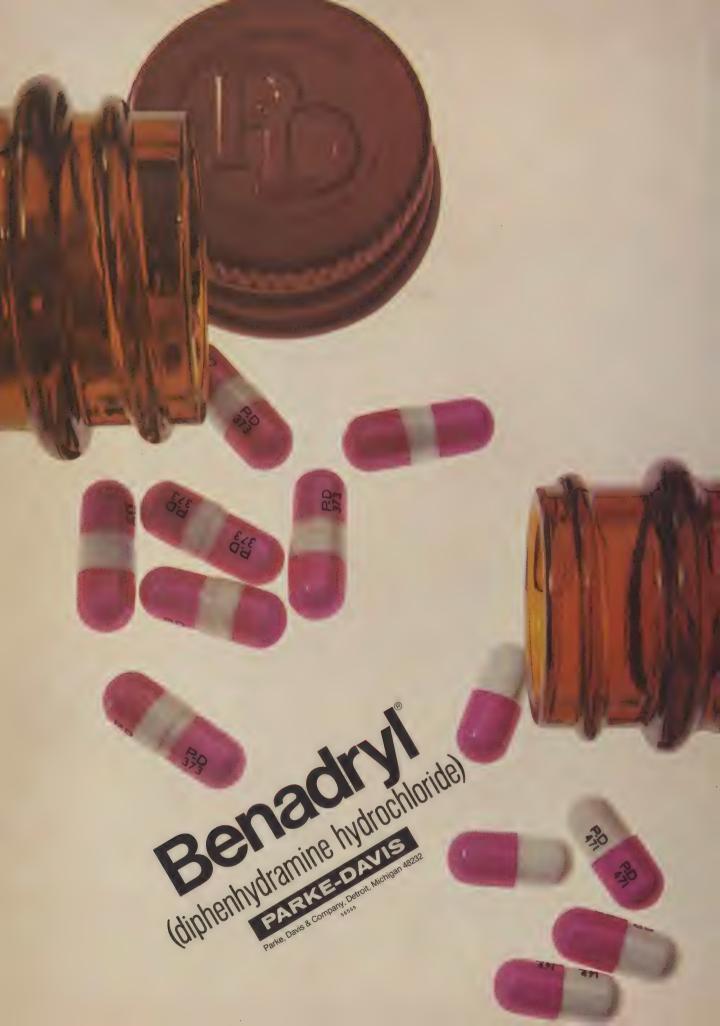
250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. When the vaginal inserts are used, one

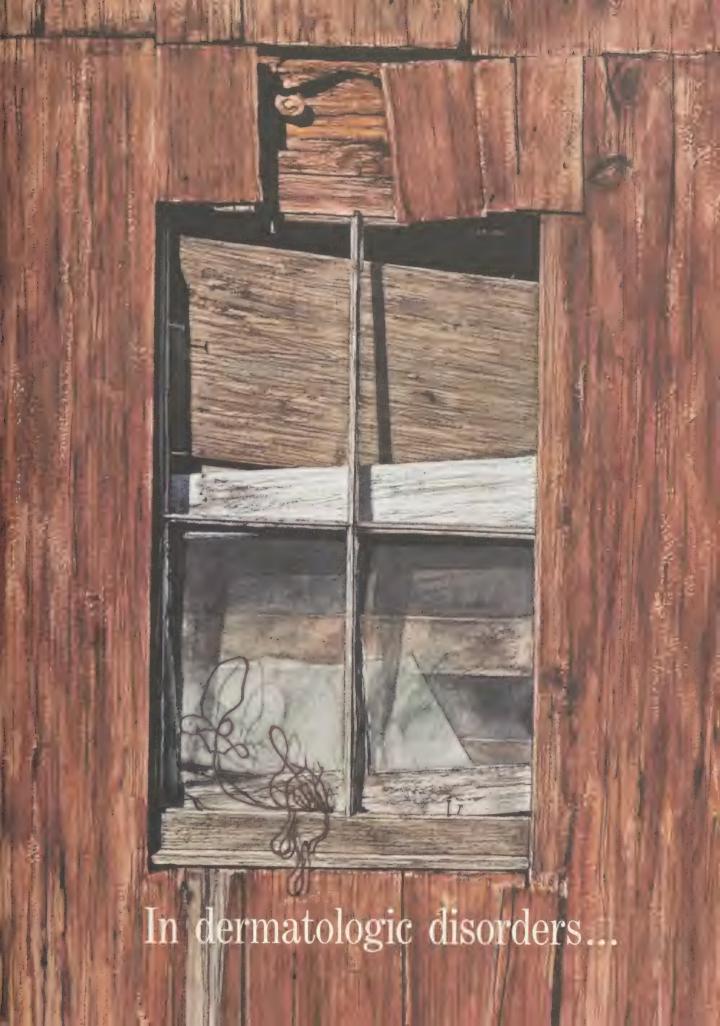
500-mg, insert is placed high in the vaginal vault 500-mg, insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg, tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. In the Male. Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg, tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his temple partner. ment of his female partner.

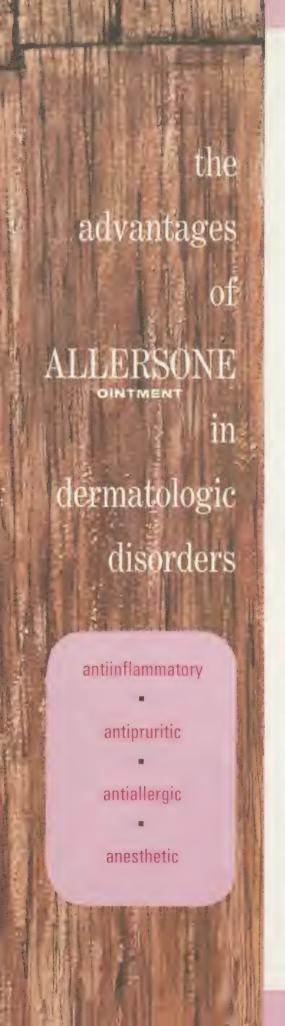
Dosage Forms: Oral tablets250 mg,
Vaginal Inserts500 mg.

G. D. SEARLE & CO.

Research in the Service of Medicine







IN THE MANAGEMENT of common dermatologic disorders, ALLERSONE provides more than symptomatic relief for your frustrated patient. Because ALLERSONE combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

ALLERSONE

OINTMENT

for effective topical management

COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain —while hydrocortisone reduces inflammation—in a water-washable vehicle —no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.



MICHIGAN WEEK AWARDS PRESENTED TO SIX MSMS MEMBERS

Six Michigan State Medical Society members were among the Michigan citizens who received special awards during Michigan Week "for outstanding service in promoting Michigan and their communities."

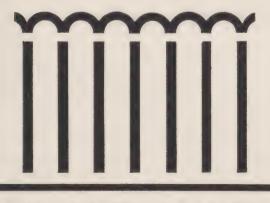
"Michigan Minuteman Governor's Awards" were presented to Robert C. Prophater, M.D., Bay City, and Marjorie Peebles-Meyers, M.D., Detroit.

"Michigan Minuteman Certificates" went to James J. Lightbody, M.D., Detroit, MSMS president; Lionel F. Swan, M.D., Detroit, president of the National Medical Association Fund; Brock E. Brush, M.D., chairman of the MSMS Committee on Public Relations, and only physician member of the New Detroit Committee, and A. Gifford Upjohn, M.D., Kalamazoo, president of the Michigan Health Council.

Doctor Peebles-Meyers was MSMS Outstanding Physician of the Year for 1968, is an alternate MSMS delegate to the AMA House of Delegates and is active in Detroit and Michigan health, welfare, educational and cultural organizations. She was selected last year as one of the "Top Ten Detroit Women Who Work" and received an honorary degree in the 1969 Central Michigan University Commencement Exercises in June.

Docton Prophater is a Bay-Arenac-Iosco Counties Medical Society delegate to the MSMS House of Delegates; president of the Bay Area Chamber of Commerce; chairman of the Bay City Advisory Board to the Apollos, a Continental Football League team; and has been chairman of the United Fund of Bay County and city commission president.

Doctor Meyers is an internist and Doctor Prophater is a general practitioner.



OUR STATE SOCIETY

Michigan Mediscene

July 31 - Aug. 2—MSMS MIDSUMMER SESSION OF THE COUNCIL, Boyne Mountain Lodge, Boyne Falls

July 31 - Aug. 2—Midsummer Meetings of Medical and Health Organizations of Michigan, Boyne Mountain Lodge, Boyne Falls

August 18—American College of Emergency Physicians, MSMS Headquarters, East Lansing, 5:00 p.m.

Sept. 15-16—29th Annual AMA Congress on Occupational Health, Stouffer Riverside Inn, St. Louis, Mo.

Sept. 18—Michigan Chapter, American College of Emergency Physicians, MSMS Headquarters, East Lansing, 7:00 p.m.

Sept. 22 – American College of Emergency Physicians, MSMS Headquarters, East Lansing, 5:00 p.m.

Sept. 28 - Oct. 2—MICHIGAN STATE MEDICAL SOCIETY 104th ANNUAL SESSION, Sheraton-Cadillac Hotel, Detroit

Sept. 28—MSMS COUNCIL, Sheraton-Cadillac Hotel, Detroit, 10:00 a.m.

Sept. 30 - Oct. 2—MSMS WOMAN'S AUXILIARY ANNUAL CONVENTION, Pontchartrain Hotel, Detroit

Oct. 1—MSMS COUNCIL, Sheraton-Cadillac Hotel, 8:00 a.m.

Oct. 12—AMA Midwestern Regional Conference on "Voluntary Health Agencies and American Medicine," Stouffer Hotel, Indianapolis

Oct. 23—2nd ANNUAL SEX EDUCATION WORKSHOP, MSMS Headquarters, East Lansing, All Day

Oct. 27—American College of Emergency Physicians, MSMS Headquarters, East Lansing, 5:00 p.m.

Oct. 29—4th Diabetes Day, Genesee County Medical Society, Flint, All Day

Nov. 5-MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

Nov. 9—MICHIGAN STATE MEDICAL ASSIST-ANTS SOCIETY, MSMS Headquarters, East Lansing, 11:00 a.m.

Nov. 19-21—American College of Emergency Physicians Scientific Assembly, Denver, Colorado

Nov. 20—Lansing Dietetic Association, MSMS Headquarters, East Lansing, 7:00 p.m.

Nov. 30 - Dec. 3—American Medical Association Clinical Convention, Denver, Colorado

Dec. 1-9th Annual Thyroid Workshop, Wayne County Medical Society, Detroit

Dec. 15—American College of Emergency Physicians, MSMS Headquarters, 5:00 p.m.

Dec. 17—MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.

Mental Health Committee Urges Sensitivity Programs Have Professional Leaders

The MSMS Committee on Mental Health has released a statement of principles approved by The Council, regarding the importance of qualified professional leaders of local "sensitivity programs" or training laboratories.

One year ago the committee began an intensive study of the techniques used and personnel involved in such local programs designed to teach "behavioral sciences by involving all segments in the community in a continuous examination of educational procedures, to look for ways to do the job better and to condition the school system in the community to make and accept changes."

"The data accumulated by the committee left no doubt that many of these programs are being conducted by unskilled and unqualified lay individuals which has resulted in participants experiencing emotional problems beyond their capacity to control," says Benjamin Jeffries, M.D., chairman of the Committee on Mental Health.

"The committee does not view all programs of this type as dangerous but does take strong objection to the group leader who conducts these programs and is incapable of recognizing emotional disturbances in the participant," he continues.

Following are the three principles adopted by the committee:

- 1. Sensitivity training can be a perfectly acceptable and valuable tool when used by professional experts trained in the fields of mental illness and mental health.
- 2. The best adequate safeguard against possible undesirable emotional disturbances and personality problems is to insure that the group leader has credentials in both academic and practical clinical experience as a qualified therapist in the mental health field.
- 3. The medical profession has the ethical responsibility to alert any person or persons interested in participating in this type of program.

U-M, MSU DEANS THANK DOCTORS

Deans of the University of Michigan School of Medicine and College of Human Medicine at Michigan State University have responded to the recent contributions to their programs made by MSMS members through the AMA-ERF Fund. Following are their letters:

Ross V. Taylor, M.D., Chairman Michigan State Medical Society Council

I have today received the check for \$11,470 representing the contributions to this Medical School by its alumni and friends in the profession.

Although the dollars themselves have an extraordinary importance because of the discretion with which they may be expended, even this importance is enhanced because of the support implicit from the profession of our efforts.

I have marked the evening of September 30th and look forward to being with you at the time of the meeting of the House of Delegates in order that a more formal presentation of these funds may be arranged.

Best personal wishes, Cordially yours, W. N. Hubbard, Jr., M.D. Dean, U-M School of Medicine

Ross V. Taylor, M.D., Chairman Michigan State Medical Society Council I was delighted to receive the check for \$1,674.90 from the AMA-ERF Fund.

As you know, these unrestricted funds are extraordinarily useful and provide a sort of freedom essential for the proper management of a medical school but most difficult to achieve from the usual funding mechanisms which are usually so highly restricted.

I shall be delighted to be present at the MSMS House of Delegates in Detroit on the evening of Tuesday, September 30 to receive officially a copy of the check.

Yours most sincerely, Andrew D. Hunt, Jr., M.D. Dean, MSU College of Human Medicine

THANK YOU FROM AFRO MUSEUM

The Editor:

The Board of Trustees of the International Afro-American Museum (Detroit) join me in this expression of our thanks for the article on "You Can Be A Doctor" in the June issue of *Michigan Medicine*. Interest in the movie has grown considerably since it was released in April. Many inquiries as to availability of the film have come to us. Copies may be obtained from the Central Office of McGraw Hill Book Co., New York City, or its subsidiaries. The unit price is \$200 and rental price is \$15.

Sincerely yours, Charles H. Wright, M.D. Detroit

Permission to Reprint MSMS Articles Asked By Many

Requests for permission to reprint all or portions of articles and illustrations in various issues of MICHIGAN MEDICINE continue to arrive at MSMS headquarters. Following are a few samples of the interest expressed by persons from around the country:

The Gelman Instrument Corporation of Ann Arbor has written *Michigan Medicine* for permission to reprint an article that appeared in the March issue. The article was titled "The Electrophoresis of Lipoproteins" and was written by John G. Batsakis, M.D., and Martha M. Thiessen, B.S., both of Ann Arbor.

Articles by three MSMS members answering the John Birch Society's attack on sex education in the public schools are going to be used by the Kansas State Department of Health in a packet of informational materials to be mailed to professional and lay citizens attempting to combat the John Birch Society's attacks on sex education in the

The articles, written by R. T. Mellis, M.D., and Frederick Margolis, M.D., both of Kalamazoo, and E. C. Galsterer, M.D., Saginaw, appeared in the May issue of *Michigan Medicine*, under the heading "Birch Society's Attack on Sex Education Answered by Three Major Articles."

Permission has been granted to Marshall Houts, editor-in-chief of the magazine, *Trauma*, to reprint an article which appeared in the February, 1968 issue of *Michigan Medicine*. The article was titled "Lap Seat Belt Injuries; The Treatment of the Fortunate Survivor," and was written by Richard C. Schneider, M.D.; William S. Smith, M.D.; William C. Grabb, M.D.; Jeremiah G. Turcotte, M.D., and Donald F. Huelke, Ph.D.

DOCTOR MERTAUGH LEADS U. P. SOCIETY

public schools.

William F. Mertaugh, M.D., Sault Ste. Marie, is new president of the Upper Peninsula Medical Society, succeeding Paul R. Lieberthal, M.D., of Ironwood. Doctor Mertaugh took office at the UP Society's recent annual meeting in Wakefield.

Approximately 125 persons attended the meeting, according to J. R. Franck, Jr., M.D., Wakefield, who was program chairman. The 1970 meeting is planned for the Soo and the 1971 meeting for the Copper Country, he reports.



NEW MSMS MEMBERSHIP

MSMS now has available a gold-filled Official MSMS Membership Pin for use in the coat lapel, as a tie tack, etc. Send check made out to MSMS for \$3.00 to Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823.



In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, N.Y.

Convalescing ... but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions,

observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recom-

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

EQUANIL (meprobamate)

Wyeth Laboratories Philadelphia, Pa.





Scientific Articles Printed to Date

Each month *Michigan Medicine* prints selected outstanding scientific articles. To date, the following papers (with month, page number and author following) have been published:

JANUARY

- Page 31, "Lower Lung Field Tuberculosis," by Ma. Zenaida Fernandez, M.D., Zamboanga City, The Philippines, and Edward G. Nedwicki, M.D., Allen Park.
- Page 36, "Use of Cholesterol Kits," by Kenneth R. Wilcox, M.D., (Reprint from New England Journal of Medicine, Vol. 279, No. 18).
- Page 37, "Mammography and Xeroradiography," by John N. Wolfe, M.D., Detroit.
- Page 39, "Early Management of Facial Nerve Trauma," by Roger Boles, M.D., Ann Arbor.
- Page 45, "Treatment of Hypercalcemia," by Joseph J. Weiss, M.D., and Jose Yanez, M.D., both of Eloise.
- Page 49, "More Drugs Mean More Problems in Managing Diabetes Mellitus," by John B. Bryan, M.D., F.A.C.P., Royal Oak.

FEBRUARY

- Page 119, "The Future of Private Practice: Salvation at the Grassroots;" by Lewis A. Miller, Stamford, Conn.
- Page 131, "Mouse Toxicity of Triple Vaccine (DTP) Mixed with Poliomyelitis Vaccine," R. Y. Gottshall, G. R. Anderson, E. A. Nelson and K. R. Wilcox, M.D., all of Lansing.
- Page 135, "Massive Intra-articular Injection of Methylprednisolone without Harmful Side Effect," by J. C. Breneman, M.D., Galesburg.

MARCH

Page 209, "Myocardial Infarction During Hyperthyroidism," by Robert C. Douglass, M.D., Southfield; Myer Teitelbaum, M.D., Detroit, and Gerald J. Aben, M.D., Southfield.

- Page 213, "Trichophyton Violaceum," by James D. Stroud, M.D.; Jules Altman, M.D., and Coleman Mopper, M.D., all of Detroit.
- Page 215, "Psychiatric Referral of a Pediatric Patient," by Joan R. Chodorkoff, Ph.D., and Bernard Chodorkoff, M.D., Ph.D., both of Detroit.
- Page 217, "Development of a Program of Laryngoscopy, Therapeutic Bronchoscopy and Endobronchial Blocking Techniques: A Progress Report," by Martin L. Norton, M.D., F.A.C.C.P., Detroit.
- Page 220, "Accidental Poisoning, Where Do We Go From Here?" by George M. Lowrey, M.D.
- Page 221, "Diabetes and Pregnancy Preliminary Report," by Nancy T. Caputo, M.D., and Agna N. Pineda, M.D., both of Detroit.
- Page 223, "The Electrophoresis of Lipoproteins," by John G. Batsakis, M.D., and Martha M. Thiessen, M.S. (ASCP), both of Ann Arbor.

APRIL

- Page 341, "Suprapubic Cystostomy In Gynecologic Surgery," by Morton R. Lazar, M.D., F.A.C.S., F.A.C.O.G., and Eugene A. Snider, M.D., both of Detroit.
- Page 345, "Rhabdomyosarcoma: Report of 20 Cases," by Lawrence S. Bizer, M.D., Detroit.
- Page 349, "Psychiatric Referrals In A General Hospital," by Wiecher H. Van Houten, M.D., Ann Arbor.
- Page 353, "The Sinai Hospital Low Vision Clinic," by Morris J. Mintz, M.D., Ernest M. Gaynes, O.D., and Arnold H. Gordon, O.D., all of Detroit.
- Page 357, "The Physician and Differential Diagnosis of Communicative Disorders in Children,"

 (Continued on Page 833)

Keep Those Cards And Letters Coming!

A state-wide organization, with all the duties characteristic of its function as the voice and helpmate of its members, still must perform another service.

It must answer queries on many subjects from the public and other professionals, who see the association as a reference source.

There was for instance a high school girl who telephoned MSMS headquarters recently and asked that she be sent, for a class report, "Everything you have on heart transplants."

By telephone, postcards, letters and even on foot - the questions come to MSMS, sometimes to the delight or chagrin of the staff.

A LARGE NUTSHELL

Imagine the reaction of the staff member who found on his desk one morning an informative communication from a county bar association containing this sentence: "In a nutshell, the goal of our two committees is to jointly promulgate a code of inter-professional standards aimed at ameliorating the usual day-to-day irritations that occur between the two professions regarding medical reports and the payment therefore, depositions, trial appearances, compensation for services rendered, etc." That had to be a large nutshell!

A retired gentleman from Jackson, Michigan, wrote asking the names of several recommended "geriatricians." In a thank you letter after his request was answered, he asked "Have you seen this poem?" Then proceeded to type it out:

> "Some folks enjoy a party And some like to wear new clothes And some take much pleasure In working with the rose."

Two recent letters have been far from cute one was scholarly, the other poignant. Both were well-written and obviously well thought out.

The first was a request for the history of Osceola County medicine and the Reed City Hospital.

The second revealed the sad plight of a 16-yearold girl who inquired for the names of local surgeons who perform rhinoplasty and concluded "... but most of all I need the names of doctors and advice on how to bring up the subject to my parents. I'm desperate and tired of being ugly."

MOST FREQUENT REQUESTS

The most frequent requests from laymen and other professionals, it seems, are for names of specialists, the state's top physicians in certain fields or an estimation of the status certain physicians hold among their peers.

The state society, which maintains no such files, or official rankings of M.D.'s according to ability or respect of peers, refers all such requests to the local medical societies who know and can recommend individual physicians better.

Such was the answer that eventually went to an impatient Ohio man who rapid-fire over long distance demanded to know "the qualifications" of a certain Michigan physician he was considering sending his wife to for treatment.

"For what?" innocently asked the young woman staff member who answered his call, thereby adding to his frustration.

INDEX TO SCIENTIFIC AUTHORS/Continued

by Gerald S. Light, M.D., and William Wolski, Ph.D., both of Flint.

MAY

The issue featured special Michigan Week articles by leaders in health care in Michigan.

JUNE

Page 571, "An Emergency Air-Ground System for Newborn Infants with Emergency Distress Syndrome," by L. J. Arp, Ph.D., R. E. Dillon, Mary Tom Long, M.D., and C. L. Boatwright, M.D., all of Blacksburg, Va.

Page 575, "Experience with Thyroid Malignancy in a Private Referral Laboratory," by Joel I. Hamburger, M.D., Southfield.

Page 581, "A Diabetic Has A Stroke," by Richard D. Hohl, M.D., Detroit.

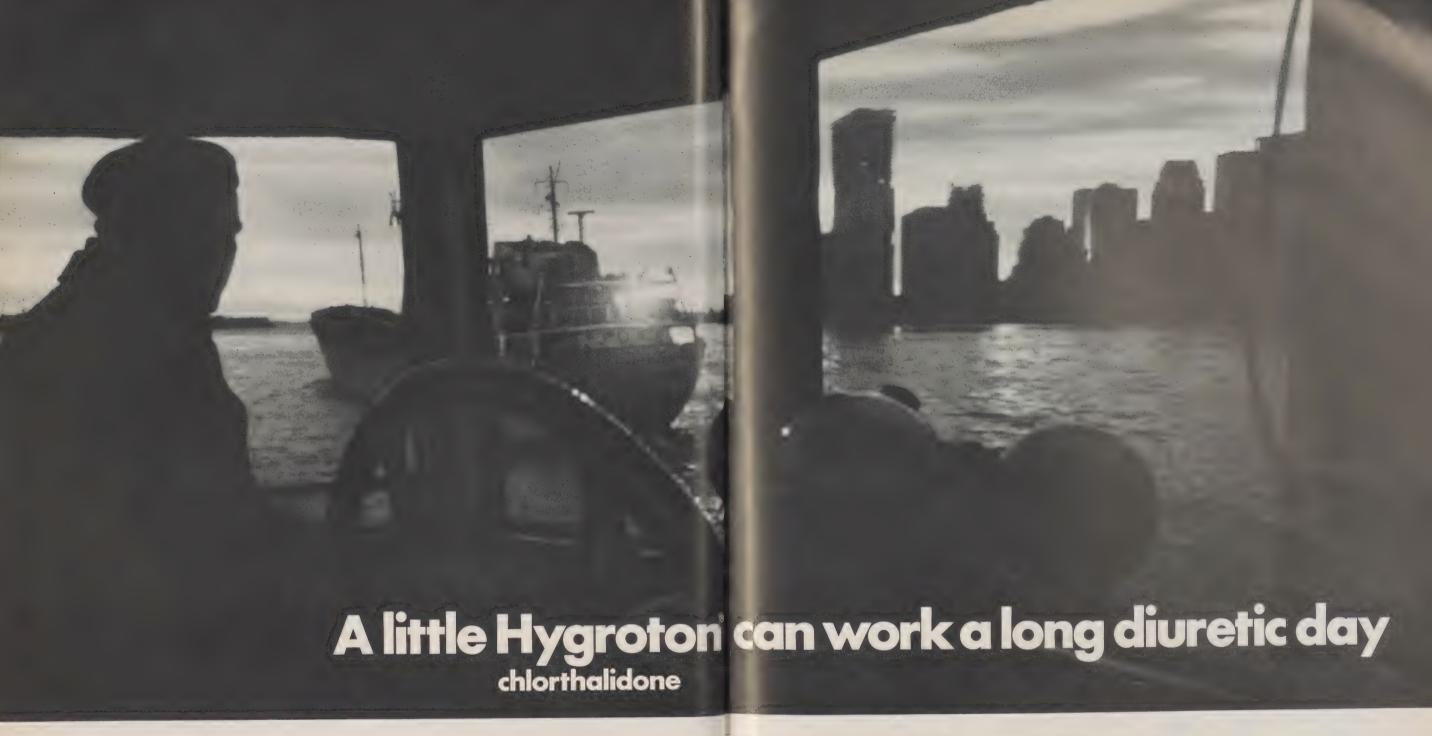
Page 581, "Night Dose May Control Brittle Diabetic," by Jack A. Litwin, M.D., Detroit.

JULY

Page 685, "Anterior Mediastinotomy As A Means of Diagnosing Bronchogenic Carcinoma," by S. Amjad Hussain, M.D., B.S., David Glow, M.D., and J. C. Rosenberg, M.D., all of Toledo, Ohio.

Page 687, "Christmas Disease With Multiple Familial Occurrence," by Frank D. Johnson, M.D., Robert K. Rank, M.D., and Robert Straley, M.T., all of Mt. Pleasant.

Page 691, "Phenylketonuria in Newborns," by K. Stanley Read, Ph.D., Lansing, Richard J. Allen, M.D., Ann Arbor, and Theresa B. Haddy, M.D., Lansing.



all the way from one daily tablet to the next to help control edema and hypertension

Its prolonged action usually provides smooth, sustained diuretic effectiveness; real one-a-day dosage, right from the start; convenience and economy.

Hygroton, chlorthalidone, can cause side effects. And it's contraindicated in hypersensitivity to the drug and severe renal and hepatic diseases.

Check the prescribing information. It's summarized on the next page.

Geigy



A little Hygroton can work a long diuretic day

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be dis-

potassium depletion may occur. It potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypoten-

sion, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.l. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.
(B)46-230-E

For full details, please see the complete prescribing information.



Geigy Pharmaceuticals Division of Geigy Chemical Corporation Ardsley, New York 10502



NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Henry A. Kallet, M.D., Jackson

David K. Hickok, M.D., (Transferred from Military), 517 Pleasant Ave., Kalamazoo 49001

Leo D. Bores, M.D., 962 Fisher Bldg., Detroit

George C. Anastasopoulos, M.D., 17555 James Couzens Highway, Detroit 48235

James E. Atkinson, M.D., 523 E. Charles St., Hastings 49058

Ahmad N. Azar, M.D., 20340 Harper, Harper Woods 48236

Todd Siu-Toa Ing, M.D., Detroit General Hospital, Detroit 48226

Arthur A. Kaselemas, M.D., 22341 E. Eight Mile Rd., Detroit 48219

Jaroslaw Muz, M.D., Grace Hospital, 4160 John R St., Detroit 48201

Helen A. Papaioanou, M.D., 20361 Mack Ave., Detroit 48236

Mohammed Rabbani, M.D., 1400 Chrysler Expressway, Detroit 48207

Thomas E. Rush, M.D., 115 Jerome Street, Midland 48640

Raymond J. Sawchuk, M.D., 14632 Berwick, Livonia 48154

Marcus B. Sheffer, M.D., 32900 Five Mile Road, Livonia 48154

V. P. Veluswamy, M.D., Pontiac State Hospital, Pontiac 48053

Robert M. Weiss, M.D., 1400 Chrysler Expressway, Detroit 48207

Bruce T. Wheatley, M.D., 16201 W. McNichols Rd., Detroit 48235

C. D. Barrett, Jr., M.D., P.O. Box 1081, Berkley 48072

Robert Edwards, M.D., SW Michigan Regional Rehab Center, American Legion Hospital, Battle Creek 49016



THE G. A. INGRAM COMPANY 4444 Woodward Avenue, Detroit, Michigan 48201 Telephone: TEmple 2-4444



The Chamber of Commerce of the United States offers "a fairy tale that has vivid meaning in today's complex world," the Chamber declares that "in fictional kingdoms or factual nations, government regulations can cause disruption, dissension and disaster."

Once Apon A Timé . . .

True or False: We live in a "regulated state?"

True

False

Many of us would quickly put a bold, black check in the FALSE box. But let's think about this a minute...

When you got up this morning, did you turn on a radio or TV set? (All radio and television stations are regulated – by the Federal Communications Commission.)

How about breakfast? Did you turn on a gas range, or plug in an electric coffee pot? (Gas and electricity are supplied by regulated companies—the Federal Power Commission has jurisdiction here.)

Have you boarded a plane or train today? (Air line companies are regulated by two government agencies—the Civil Aeronautics Board and Federal Aviation Administration. All rail transportation is regulated—by the Federal Interstate Commerce Commission.)

The list could go on and on. But you get the idea:

Practically every facet of our daily lives is touched — to a greater or lesser degree — by federal regulation.

Here is a comment from Arch N. Booth, Executive Vice President of the National Chamber:

"The scope and complexity of today's business world does call for a *limited* and *proper* degree of government regulation of business . . ."

But note the big when and if implied. The simple fact is:

Government regulatory commissions serve a vital function in our economy . . . WHEN they carry out, vigorously and impartially, their responsibilities under the law . . . and IF they resist any tendency to substitute federal edict for management decision.

Suppose they go beyond or violate this when and if? What then? As citizens, what can we do about it? Keep this in mind:

All Federal bureaus which regulate our communications, our utilities, our transportation, our food and drugs, and so forth - were established by Congress.

The laws – under which they are supposed to operate - were written by Congress.

And Congress — is the people!

Every Representative, every Senator, serves at the pleasure of you — the voting citizen.

So if we have good federal regulation — fine!

But if we have bad federal regulation - then you have the means to change it.

Well, you may ask, what has all this got to do with me? I can't see regulation. I can't feel it. I hear music and news, I watch TV. I have my coffee, mornings, with scrambleds. I ride the rails, or fly – federal regulations or no. So, what's the difference?

The difference, my friend, is very real – and just this:

Overzealous government regulation jeopardizes the economic health of a vast segment of the American economy.

Still not personal enough? Well then, look at it this way:

If a strait-jacket held back a fifth of your ability to deliver effective punches, how many fights do you think you would win?

That's what over-regulation means to American business - to you.

The problem of over-regulation is not simple any more. But don't let this scare you off - the problem is continually undergoing scrutiny. And

simple answers to complex problems show up within the National Chamber, local and state chambers of commerce, trade and professional associations. Use their helping hands.

Needed, of course, to avoid over-regulation are improvements in legislative acts, constructive alternatives.

Tell a legislator you helped elect not only what is wrong but what to do about it and you - and he — can get somewhere.

Naturally, too, you will want to keep your eye on Congress. And react.

Tell yourself, and believe it – because it is true: I count for something.

Remember: You elect Congress - you and others like you.

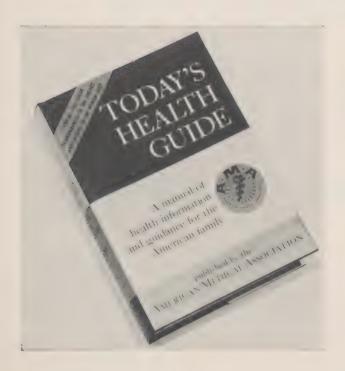
And: Congress regulates the regulators.

You need have no hesitation whatsoever in calling on, writing to or visiting with your Member in Congress or the Senators from your State. They want to hear what you have to say . . . if it is constructive and useful. And your voice – from home - strengthens their voice when they speak and act on the floors of the House and Senate.

You, as an individual, can do a great deal more perhaps than you realize - to keep government intervention within the economy in reasonable limits.

You can discipline yourself, inform yourself more fully, and then work for appropriate action.

Serve as a complete citizen. Fulfill your rightful and responsible role in the making of decisions that will help build a better nation for us all.



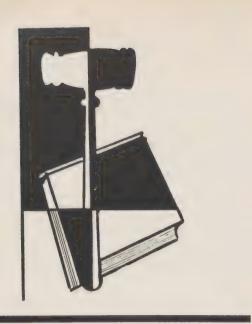
FOR YOUR PATIENTS:

Today's Health Guide is an up-to-date, 640-page, family health reference that should be in every home. The AMA's long awaited new book, Today's Health Guide, is the product of 200 of the world's most renowned authorities in medicine, science and allied fields.

The Guide discusses more than 2,000 illnesses, diseases and other medical subjects including diet and nutrition, child care, safety and first aid, sex education, mental health and when to seek professional medical attention. Over 300 striking illustrations and an eight-page full-color transparency of the human body vividly complement the text.

Today's Health Guide is the medical profession's answer to the need for an inexpensive yet authoritative and comprehensive home health guide.

Your patients may obtain one by sending a check or money order for \$5.95 for each copy to the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.



LEGAL

(Editor's Note: The following articles are quoted from the AMA Citation Newsletter of May 15, 1969, prepared by the AMA Law Department.)

MISFILLING OF PRESCRIPTION FOR "THE PILL"

A suit by a patient and her husband against a druggist for damages resulting from the birth of a normal child as the result of the druggist's alleged negligence in furnishing her with a tranquilizer instead of the birth control pills that had been prescribed was dismissed by a Michigan trial court. To allow a cause of action in such a case would be contrary to public policy.

In August, 1964, the patient, who had seven children, consulted her spiritual adviser and her physician about a planned parenthood program. The physician prescribed Norinyl, an oral birth control pill. It was alleged that the druggist furnished the patient with Nardil, a mild tranquilizer. The patient took the pills furnished until January, 1965. On August 12, 1965, she gave birth to a healthy boy.

In this suit, the patient and her husband sought to recover as damages the costs of the confinement, the patient's loss of earnings, support for the child until he is 21, and for emotional stress and strain incident to pregnancy.

In our society one of the prime objectives of marriage is the procreation and rearing of children. Damages cannot be awarded for the result of the natural conjugal act of a husband and wife. To allow damages in a suit such as this would mean that a physician or a druggist, as in this case, would have to pay for the conjugal pleasure and affection that the patient and her husband have had and will continue to have in the raising of the child.

Planned parenthood is admittedly openly and notoriously advocated by many sociologists, many physicians, some moralists, some religious leaders, and even some governments. That public policy was not sufficient to justify placing a moral or legal responsibility on the druggist to assume the costs of the natural result of a natural act of the marital relationship. Any public policy favoring planned parenthood that may exist is outweighed by the public policy requiring the responsibility of parenthood to be borne by the parents. - Troppi v Scarf, Cir. Ct., Wayne Co., Docket No. Civil Action 53523 (Mich., March 24, 1969)

from Vol. 19, No. 3

INACCURATE JURY ARGUMENT NOT REVERSIBLE ERROR

A hospital was not entitled to a new trial in a suit by a patient who suffered injury to his left ulnar nerve as the result of the way he was positioned on or secured to the operating table, the Michigan Supreme Court ruled. A misleading remark about the table which the patient's attorney made in his closing argument was not reversible error, where the argument was not so prejudicial as to be beyond repair by a corrective instruction, and the hospital failed to save the question for review, either by a motion for mistrial or a request for a corrective instruction.

In his closing argument, the attorney stated that the hospital had failed to produce the table in court in response to a subpena. He had, in fact, subpensed the anesthetist to produce the table. She was not a hospital employee, had no control over the table, and thus could not produce it. The hospital did nothing more than object to the remark.

The misleading and inaccurate statement by the patient's attorney could easily have been remedied by a corrective instruction if the hospital had requested one.

Further, something more than an objection to an allegedly improper jury argument is necessary in order to save the question for appellate review. If defense counsel thinks that his defense has been incurably damaged by a prejudical closing argument, the remedy of a prompt motion for mistrial is available. If he considers the matter reparable by the trial court, a formal request for judicial correction is not only in order but tactically valuable.

Since the hospital did nothing more than object to the remark, it was not entitled to a new trial. - Koepel v St. Joseph Hospital and Medical Center, 163 N.W.2d 222 (Mich., Dec. 27, 1968)

Editor's Note: The appellate court's decision was reported in THE CITATION, Vol. 16, No. 12, p. 181.

from Vol. 19, No. 3

RECOVERY FROM PHYSICIAN'S MALPRACTICE INSURER

Damages awarded to a patient's husband in his suit against a physician for breach of contract and loss of society, companionship, and consortium came within the clause of the physician's malpractice insurance policy providing coverage for injury resulting from failure to render professional services. Therefore, the husband's suit against the insurance company for a writ of garnishment was improperly dismissed, a Michigan appellate court ruled.

The husband's suit against the physician was based on the theory that he breached an implied contract by failing to use "standard treatments" in treating the patient. The jury awarded the husband the lump sum of \$14,000 for breach of contract and for loss of society, companionship, and

consortium.

The policy provided that the insurance company would pay all sums which the physician became obligated to pay as damages because of injury arising out of malpractice, error, or mistake in rendering or failing to render professional services.

The policy does not define "injury." Injury may be physical, as it was with the patient, or it may be mental or economic, as it was with her husband. Injury has been defined as any wrong or damage done to another, either in his person, rights, reputation, or property. A fair application of the policy terms "injury" and "failing to render professional services" will cover the damages found to have been suffered by the patient's husband as the result of the physician's malpractice. — Squires v Hayes, 164 N.W.2d 565 (Mich., Sept. 25, 1968)

from Vol. 19, No. 3



This attractive office plaque, available from the American Medical Association, will encourage better understanding between you and your patients. Suitable for wall or desk display, the plaque measures 6" x 10½". The lettering is white on a dark brown background and the frame is durable beige plastic. The plaque is designed to

blend well with any office decor. Cost of the plaque is \$1.25, postpaid. To place your order, write to the Order Department, American Medical Association. Make check payable to the AMA.

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PLAINWELL SANITARIUM, INC.

Plainwell, Michigan — MU 5-8441

M. Leroy Barry, M.D.

Dan W. Everett, M.D. Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.



The heavy smoker with vasospasm

He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

Thus, a history of heavy smoking coupled with vasospasm may serve as warning signals to the physician. When a diagnosis is established, therapeutic measures are directed toward increasing the local circulation, and appropriate management of the patient's general medical needs should be instituted. These include the important safeguards of keeping warm and refraining from smoking.

Before prescribing Roniacol Timespan (nicotinyl alcohol tartrate), please consult complete product information, a summary of which follows.

Indications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo. Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets morning and

How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50.



Important in total management of peripheral vascular disease, vascular spasm or chilblains Roniacol Timespan (nicotinyl alcohol tartrate) for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.

Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.

Selectivity of action—relaxes the musculature of peripheral blood vessels.

High degree of safety—side effects seldom require discontinuation of therapy.

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic / antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also,

at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium

WARNINGS: Caution patients about possible

combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and toler-



ated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

ADVERSE REACTIONS: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These

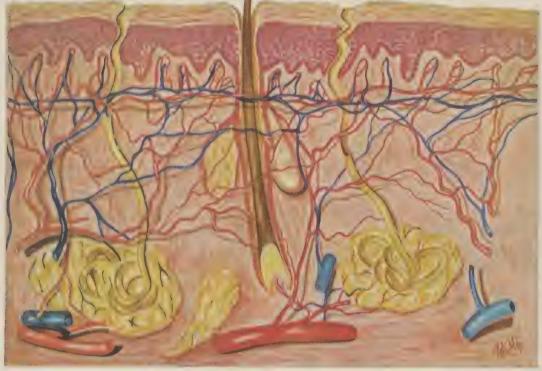
are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.



JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B -bacitracin-neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

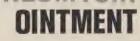
Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., $\frac{1}{2}$ oz. with applicator tip, and $\frac{1}{8}$ oz. with ophthalmic tip. Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'

POLYMYXIN B-BACITRACIN-NEOMYCIN





BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin

Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and

may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. Kidney—dose-related rise in BUN. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Intracranial—bulging fontanels in young infants. Intercept—yellow-brown staining; enamel hypoplasia. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



Our travel-pak for summer cold and allergy sufferers.

Novahistine LP can speed your patients on their way, by providing prompt and continuous relief from the symptoms of summer colds and allergies. These continuous-release tablets contain a vasoconstrictorantihistamine formulation that goes to work rapidly and lasts for hours. Even when nasal congestion is caused by repeated allergic episodes, the convenient twice-a-day dosage of Novahistine LP makes it easy for most

patients to enjoy relief all day and all night. When symptoms are severe, a third dose of one or two tablets may be safely given. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.



(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)





The Community Hospital Education Committee of Lansing, which coordinates the new continuing education series of meetings for local M.D.s and D.O.s, includes, from left, Richard Pomeroy, M.D., William Weber, M.D., Joseph Caruso, M.D., R. D. Wirt, D.O., L. George Suhrland, M.D., and T. Calvin Blair, M.D., pictured at a meeting at Lansing's Sparrow Hospital.



M.D.s AND D.O.s talk at luncheon at MSU's Kellogg Center during a joint all-day continuing education session sponsored by a unique Lansingarea M.D.-D.O. committee.

Lansing Area M. D.s and D. O.s Unite For Continuing Education Seminar Series

BY JUDITH MARR MANAGING EDITOR

Medical doctors and osteopaths in the Lansing area are building greater respect and closer working relationships among themselves through a unique continuing education program.

Sponsored by the four Lansing hospitals and Michigan State University's College of Human Medicine, visiting professors are brought to the Capitol City to speak to combined groups of M.D.s and D.O.s.

The program is planned and coordinated by the Community Hospital Education Committee, which has both M.D. and D.O. members. The first two joint meetings were held last spring and several more are scheduled for the coming year.

The all-day educational meetings have improved personal relationships between the M.D.s and D.O.s who attend, comments Richard Pomeroy, M.D., Lansing, one of the original committee members and director of medical education at Lansing's E. W. Sparrow Hospital.

"We've gotten to know one another better in a scientific atmosphere," he observes.

The committee this summer planned five meetings for the 1969-70 season, with the theme of "Juvenile Medicine" to be approached from pediatric, surgical, medical and psychiatric aspects.

Last year's theme was "Problems of the Newborn." Speakers featured included Robert Wilson, M.D., chief of the Mayo Clinic's Department of Obstetrics and Gynecology, and Robert A. Miller,

M.D., director, Department of Pediatric Cardiology, Cook County Children's Hospital, Chicago.

The usual format for each session, which will be followed in the upcoming season's offerings, calls for one major evening discussion, plus appearances by the physician at other conferences and clinics at the local hospitals and MSU.

The response has been good, says Doctor Pomeroy, particularly to the idea of the guest lecturer being in the Lansing area for more than one meeting during the day.

Invitations are specifically extended to M.D.s and D.O.s at Lansing hospitals, but the meetings are open to any interested central Michigan physicians, according to Doctor Pomeroy.

Attendance at the first two meetings, viewed as a major collaborative effort by M.D.s and D.O.s in the area, averaged about 60, he says.

Besides Doctor Pomeroy, committee members who have been working on the unique joint sessions since fall, 1968, include William Weber, M.D.; L. George Suhrland, M.D.; Robert D. Wirt, D.O.; Joseph Caruso, M.D.; F. M. Dunn, M.D. and T. Calvin Blair, M.D.



VISITING CHICAGO PROFESSOR Robert A. Miller, M.D., director, Department of Pediatric Cardiology, Cook County Children's Hospital, was one of two physicians featured in day-long M.D.-D.O. meetings and clinics at Lansing hospitals and MSU.

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The Michigan Department of Civil Service has instituted a plan to implement multiphasic screening tests of state employees at the request of the State Employees Group Insurance Advisory Committee to the Civil Service Commission. The following is a complete report on the new health maintenance program, by John A. Cowan, M.D., medical director of the Group Insurance Unit.

Multiphasic Screening Tests of State Employes Explained in Detailed Report

BY JOHN A. COWAN, M.D. MEDICAL DIRECTOR STATE EMPLOYEES GROUP INSURANCE HEALTH MAINTENANCE UNIT

The State of Michigan is the largest employer of people in the Lansing area, yet it is probably the only large employer which does not have independent medical services for its employees. At the request of the State Employees Group Insurance Advisory Committee to the Michigan Civil Service Commission, the Commission has instituted a plan to implement multiphasic screening tests under the already existing state contributory health insurance program.

Experience has shown that multiphasic screening examinations have often brought to light so-called hidden diseases in a stage when they were most treatable and at a time when the doctor can most effectively and efficiently help his patient maintain or regain good health. These programs also develop an interest in health maintenance among people who have not previously done so and educate them in the advantages of the physi-



ANCILLARY SECTION

cian-patient relationship. Multiphasic screening programs also serve as an epidemiologic tool and provide a vehicle for feasibility and demonstration studies. These studies have demonstrated a positive impact on such programs on the health and sickness experience of specific populations where they have been used.

MOST PHYSICIANS WILL AGREE that early diagnosis often makes it possible to successfully treat many diseases where this would otherwise not be the case. The discovery of the disease in the pre-symptomatic stage offers the greatest hope for cure or prevention of complications or disability. It has been proven that multiphasic screening programs offer one of the best hopes for the early detection of disease and successful medical management. With the critical physician shortage, it is impractical to conduct annual physical examinations on most patients. The screening program is not a substitute for such physical examinations, but rather detects those in the population being screened who are most likely to benefit from such an examination.

Currently, 39,000 of the approximate 44,000 state employees have coverage for physician and hospital expenses. Many state employees may have a personal physician, although there are probably a significant number who do not have, and it is believed that the tests will encourage them to develop this relationship. The information gained from the screening tests will be of invaluable help to the doctor in taking care of these patients.

The Michigan State Employees Health Maintenance Program was implemented in Ingham County beginning July 1, 1969. We will utilize three permanent sites in Lansing, Kalamazoo and Detroit; one mobile unit will also screen employees in other areas of the state. It is anticipated that the clinics in Kalamazoo and Detroit, as well as the mobile clinic, will be in operation in the near future. Reports from the tests will not be given to the employee. The employee will only

get a report that the results of the tests indicate it is advisable that he contact his physician, or that the tests were all within normal limits. Most of the tests will be automated and the results will come on a print-out from the computer and go to the employee's physician. It will list not only the tests made, but what is considered the normal range and variation of such tests. It should be emphasized that a diagnosis is not made and treatment is neither advised nor given. The program conforms with the screening guidelines adopted by the Michigan State Medical Society.

SPECIFIC TESTS TO BE performed include:

A self-administered medical history, which is a modified variation of the old Cornell medical history form.

Chest X-ray (70 mm.) — interpreted by a chest physician.

12 Lead EKG – interpreted by a cardiologist. Fairly large series of blood chemistry and hematology tests, such as Blood Sugar, LDH, Alkaline Phosphatase, Total Protein, Total Bilirubin, Calcium, Cholesterol, Creatinine, Uric Acid, Inorganic Phosphorus, Albumin, S.G.O.T., VDRL, WBC, RBC, Hemoglobin and Hematocrit.

Blood pressure

Tonometry

Urinalysis – ketone, occult blood, protein, glucose and bacteriuria

Papanicolaou smear – interpreted by a pathologist.

Vision and hearing screening.

The tests are performed by specially trained nurses and technicians, all under the direction of a physician.

IT IS HOPED THAT early detection of presymptomatic disease will benefit both the physician and his patient. The program should benefit the physician by supplying him with information about persons who presumably have one or more abnormal conditions and also should be of value in furnishing him with base line information on his patients who apparently have had no abnormal tests. This information certainly should prove to be a time-saving device for the physician. In actual practice, the benefits of the screening program can only be realized by physician cooperation and physician utilization of the screening program results. The physician will play the key role in this program. These activities will make recent advances in preventive medical techniques available to both the physician and his patients.



(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1.SUMMARY

ANDROID

GOOD TO EXCELLENT 75%

PLACEBO

20%

*"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS - Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths Android-HP Android

Each yellow tablet contains: Each red tablet contains: Methyl Testosterone . . 2.5 mg. Thyroid Ext. (1/6 gr.) . . 10 mg. .50 mg. Dose: 1 tablet 3 times daily. Dose: 1 tablet 3 times daily. Bottles of 100, 500, 1000.

 Methyl Testosterone
 .5.0 mg.

 Thyroid Ext. (½ gr.)
 .30 mg.

 Glutamic Acid
 .50 mg.

 Thiamine HCL
 .10 mg.

Available: Bottles of 100, 500, 1000.

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EXTRA HIGH POTENCY

Dose: 1 or 2 tablets daily. Available: Bottles of 60, 500.

REFER TO PDR

2. Forty cases reported. Cites synergism between androgen and thyroid. No side effects in patients treated.

cannot be disputed.

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Each white tablet contains:

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Thiamine HCL ... 25 mg.
Glutamic Acid ... 100 mg.
Pyridoxine HCL ... 5 mg.

Dose: 2 tablet twice daily.

Available: Bottles of 60, 500

Vitamin B-1 Riboflavin

5. Alleviation of fatigue noted 6. Case histories on 4 patients. 7. Although psychotherapy still needed, role of

also available with ESTROGEN

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Each Tablet Contains:

Glutamic Acid ... 50 mg. Molications. 50 mg. Molications. Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. 00\$£: One tablet 1i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIDE EFFECTS: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsultism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg, of testosterone per month. CONTRA-INDICATIONS: See Android. Ethingl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Write for literature and samples:

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MICHIGAN BLUE SHIELD TESTS PILOT PROGRAM IN FIVE COUNTY SOCIETIES

A three-month pilot program is being conducted in five county medical societies by Michigan Blue Shield because of the concern expressed by some doctors regarding letters sent to physicians and their patients under certain circumstances in the administration of the Michigan Variable Fee Program.

The five county societies in which the program is being tried are Oakland, Genesee, Grand Traverse-Benzie-Leelanau, Kent and Muskegon.

In this program, Blue Shield is using a modified procedure in handling certain of the "over-the-screen" situations by non-participating physicians. The letters currently in use are sent to non-participating doctors and their patients only in those few cases in which the non-participating doctor chooses to use the "Pay Subscriber" service report form and then only if the doctor's customary charge exceeds the current prevailing charge screen for the general area by less than \$75.00.

In those cases falling within the Pilot Program (i.e., cases with differences of less than \$75.00 and over five dollars between the doctor's charge and the prevailing screen) Blue Shield will delay for approximately 30 days the letter to the subscriber that is being sent at the same time the doctor's letter is being sent under the current approach. Correspondence will be forwarded to the doctor giving him the opportunity to express himself regarding the case in detail.

The test program, which began June 9, will be used as a comparison with the former procedure and might replace the present procedure entirely.

New MSU Sama Head

William Lynn Cooper of Mt. Clemens is new president of the Michigan State University Sama Chapter.

AMA's "Horizons Unlimited" Popular Film

"Horizons Unlimited," the AMA motion picture film on careers in medicine and allied fields, has been viewed by over three million students across the United States since its release just a year ago.

The 28-minute film has had more than 8,500 showings, approximately 7,400 of them to student and other non-medical audiences.

Michigan physicians interested may obtain the film through the Michigan Health Council, 712 Abbott, East Lansing 48823.

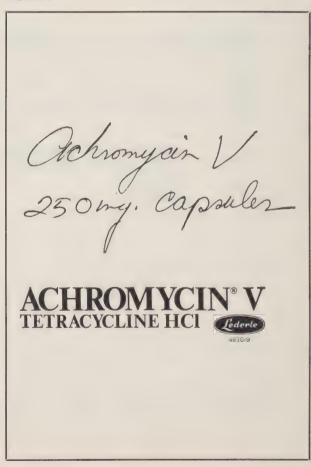
FIRST MICHIGAN USE OF NEW DRUG MADE IN ANN ARBOR

Doctors at the University of Michigan Medical Center made the first known human use in Michigan of antilymphocytic globulin (ALG) in treating a young Benton Harbor woman before and after a kidney transplant in June.

The use of the ALG followed nearly two years of planning and research between U-M doctors and Upjohn Co. scientists from Kalamazoo. The serum is being introduced for limited use on humans pending final approval and certification by the Division of Biological Standards at the National Institutes of Health.

Medical Items Among State's Top Products

Three medicine-related Michigan products were among 10 regional winners submitted in hopes of being proclaimed Michigan Product-of-the-Year during the recent Michigan Week observation. They were replaceable plastic finger joints, called Silastic, by Dow-Corning, Midland; a computer that analyzes a patient's blood chemistry, called Digiscreen and produced by the Gelman Instrument Co., of Ann Arbor, and an automatic traydelivery system for small items in office or hospital, called Webb-Tray System, by Jervis B. Webb Co., Detroit.



MICHIGAN DOCTORS APPEAR ON 'FORMULA'

Several Michigan doctors have been recent guests on the MAP-sponsored television show, "Formula," hosted over WIIM-TV. Lansing, by the executive director of both MAP and MSMS, Hugh W. Brenneman

Doctors who recently have been interviewed and their topics, include: May 4, "Formula for Nursing," with Roger B. Nelson, M.D., Senior Associate Director, University Hospital, Ann Arbor; May 25, "Formula for Healthy Activity," Jerome S. Kozak, M.D., Lansing, specialist in orthopedic surgery, and James S. Feurig, M.D., East Lansing, director, Olin Memorial Health Center and Team Physician, Michigan State University Spartans; June 8, "Formula for Counseling for the Professions," Ross V. Taylor, M.D., Jackson, chairman of The Council, MSMS; June 15, "Formula for New Hearts," Donald R. Kahn, M.D., Ann Arbor, associate professor of surgery, University of Michigan Medical Center, and June 22, "Formula for the Poor," William W. Moon, M.D., Baldwin, director, Comprehensive Health Center, Baldwin.

Escanaba Facility Opens

Medicenters of America in Escanaba opened a 60-bed unit June 9 in Doctor's Park. The Medicenter is owned and operated by Willow Creek Development Corp., a group of prominent business and professional people in Escanaba.

The facility, built at a cost of \$550,000, offers extensive treatment programs for the recuperating patient, including physical therapy, diagnostic Xray, and pharmacy and laboratory services.

RADIOLOGISTS DISCLAIM CHIROPRACTIC

The AMA urges physicians to advise their patients that the American College of Radiology regards the use of radiation by chiropractors as "unwarranted and without likelihood of significant medical gain."

The College of Radiology joined other scientific and medical groups in stating this spring that the practice of chiropractic "constitutes a dubious benefit to patients who seek health care."

The Board of Chancellors and Council of the College approved a resolution saying "chiropractic training does not adequately cover the use of ionizing radiation for detecting disease and injury."

Michigan Ranked In AMA Statistics On Medical Students

AMA statistics on the numbers of young Michigan men entering medical schools during the last several years include these figures:

In 1960, 333 Michigan students entered medical school, ranking the state seventh in total numbers of residents entering medical schools inside and outside the state.

In 1963, 319 young Michigan people entered medical schools around the country, ranking the state seventh again.

In 1968, there were 363 young Michigan people entering medical schools, and the state ranked eighth. Of the total 363, sixty-six entered medical schools in other states, the remaining entered home state schools.



B) is composed of the antigen of the strains of influenza viruses recommended by the Division of Biologics Standards, National Institutes of Health, Public Health Service. It is formulated to contain 400 CCA (chick cell agglutination) units of extracted immunizing antigen of type A2/ Aichi/2/68 strain (Hong Kong variant) and 300 CCA units of extracted immunizing antigen of B/Massachusetts/3/66 strain for a total of not less than 700 CCA units per each 0.5 cc. dose. Method of Preparation: The influenza viruses are propagated on developing chick embryos. The extra-embryonic fluid containing the virus suspension is harvested, clarified by filtration and concentrated and refined by ultracentrifugation. Polysorbate-80, U.S.P. (175 mcg. per 0.5 cc.) is added to the refined concentrate. The refined concentrate is extracted with ethyl ether, stabilized with formalin, and preserved with 0.01% thimerosal (mercury derivative). The vaccine contains not more than 1:12,000 formalin, used during the process. It does not contain penicillin. Aluminum phosphate, 1.5 mg. per 0.5 ml. is added to the vaccine as an adjuvant. Indications: FLUOGEN is indicated for the production of immunity to influenza produced by the strains of virus containing antigens related to those in the vaccine. FLUOGEN is recommended primarily as a seasonal booster for persons who were previously vaccinated with vaccines containing the A2 Hong Kong variant. It may also be used for primary immunization of those who have not previously received the Hong Kong variant. It is recommended that both primary and booster immunization be completed by early December since influenza is more likely to appear during cold weather. It is understood that should epidemic conditions be predicted, immunization procedures should be initiated regardless of the time of year. Attempts to produce immunity following the appearance of an epidemic may be less successful because of the rapidity with which the disease spreads and the time required for antibody pro-FLUOGEN[™]
(influenza virus vaccine, bivalent) immunizing duction following vaccination. The degree of protection afforded by immunization with any vaccine may not be sufficient to prevent the disease if the exposure to the influenza virus strains is overwhelming or if the virus strains are not closely related antigenically to those used in the production of vaccine. Although routine vaccination of healthy groups of adults and children is not recommended, when widespread epidemics of influenza are forecast, vaccination may be considered antigen, ether extracted if above-average levels of absenteeism would disrupt satisfactory operations in industries, schools, and other such groups. Contraindications: The use of products prepared from the embryonic fluid of chicken eggs is contraindicated in persons with a history of allergy to eggs, chicken, chicken feathers, or chicken dander. In persons suspected of having an allergic condition, immunization procedures should be preceded by a scratch test or an intradermal injection (0.05 ml. to 0.1 ml.) of vaccine diluted 1:100 in sterile saline to determine possible sensitivity to the minute residual egg protein that may be present in the vaccine. A positive skin reaction contraindicates immunization with the vaccine. Immunization should be deferred in the presence of any acute respiratory disease or other active infection. It should also be deferred in the presence of an epidemic of poliomyelitis unless the risk of influenza represents a greater threat to the patient than the increased possibility of poliomyelitis. Precautions: A separate sterile syringe and needle should be used for each patient to prevent transmission of homologous serum hepatitis virus or other infectious agent from one person to another. Reusable glass syringes and needles should be heat sterilized. Epinephrine should be immediately available for use should an acute anaphylactoid reaction occur in individuals having an undisclosed hypersensitivity to any component of the vaccine. Because of the possibility of a febrile reaction following immunization with influenza virus vaccine, the wisdom of attempting to immunize patients with a history of febrile convulsion should be given careful consideration. Adverse reactions: Most frequent reaction reported in early clinical studies† with ether-extracted vaccine was tenderness at the site of injection. Headache and malaise were reported in up to about 12% of subjects, Nausea and fever occurred in approximately 5% of the patients. Muscle ache, joint pain, chills, fatigue, and anorexia occurred in less than 5% of the subjects. Package information: Bio 579 - 5 cc. rubberdiaphragm-capped vial. Each 5 cc. vial contains sufficient vaccine to deliver ten 0.5 cc. doses. †Unpublished data available upon request.

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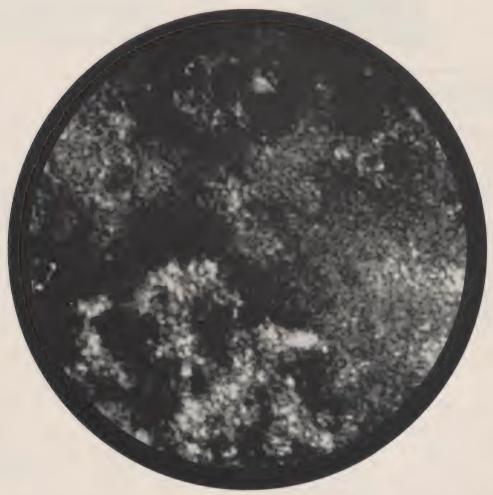
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Combined Local and Systemic Reactions in 3,929 Patients*



*Summary of results from three studies. References available on request.



COUNTY SOCIETIES

ANN ARBOR PROFESSOR ADDRESSES BAY MEMBERS

At their final meeting of the 1968-69 season, members of the Bay-Arenac-Iosco Counties Medical Society heard a talk on inhalation therapy by Thomas Bekorfeld, M.D., professor of anesthesiology at the University of Michigan. The county society members in May held a question-answer meeting with representatives of Michigan Blue Cross-Blue Shield.

MUSKEGON SOCIETY CITED IN "PR DOCTOR"

A recent issue of *PR Doctor*, an AMA publication, cited the Muskegon County Medical Society in an article of state society activities promoting Community Health Week. The Muskegon Society's activities in sponsoring school assemblies, radio discussions and distribution of over 15,000 AMA health education and career pamphlets to students during Community Health Week were lauded. So praised, also, was the West Michigan organization's efforts in offering the services of its School Advisory Committee to each school principal and singling out members of the local National Honor Society and science clubs to encourage their interests in health careers.

STATE POLICE AWARD KENT COUNTY

The Kent County Medical Society has accepted an award from the Michigan Law Enforcement Officers Training Council for its work in establishing and upgrading local emergency medical care. The award was accepted at a recent recruit graduation ceremony by Kent Society member John Wilson, M.D.

Oakland Survey Reveals Physicians' Attitudes On Key Medical Issues

An indication of the thoughts and opinions of physicians throughout Michigan on a variety of urgent political and economic problems was made by the results of a survey of Oakland County Medical Society members taken in May.

According to Robert J. Mason, M.D., Birmingham, president-elect of The MSMS Council and representative from the Oakland County Society, an overwhelming 66 percent of the doctors returned completed questionnaires, many including personal comments.

Among the results:

- 1) The great majority of Oakland County M.D.'s 87 percent desired a change in the abortion statutes in Michigan.
- 2) 85 percent of the Oakland doctors favored a single medical practice act bringing M.D.'s and D.O.'s under the same jurisdiction.
- 3) 51 percent rejected disassociation of MSMS with Michigan Blue Shield, while at the same time favoring a change in the status of Michigan Blue Shield to an ordinary commercial insurance carrier in the health care field.

In more specific points of the abortion issue, according to Doctor Mason, 55 percent of the Oakland doctors favored a full liberalization of the statutes making abortion a mere medical problem, subject only to the judgment of physician and patient, while 45 percent were in favor of liberalization for certain specific conditions such as rape and incest.

Oakland County M.D.'s opted for accepting D.O.'s on their hospital staffs (70 percent) and in internships and residency programs in their hospitals and in their specialties (75 percent). A free interchange of M.D.'s and D.O.'s qualified in all Michigan hospitals brought the approval of 68 percent of those polled but the acceptance of osteopathic specialists on an equal basis with medical specialists for hospital privileges was rejected by 55 percent of the membership.

Fifty-seven percent of the 413 replies from the members indicated that they fully participated in Michigan Blue Shield, stated Doctor Mason.



NEWS BRIEFS

GORDON A. EADIE, M.D., NEWBERRY,

has taken a new position as Health Commissioner of Rensselaer County, New York State. Doctor and Mrs. Eadie moved in June to Troy, N.Y., from Newberry, where Doctor Eadie was director of the Luce-Mackinac Health Department.

GEORGE M. BROWN, M.D., BAY CITY,

at 79 the oldest physician in his community, was active collecting funds for the local political campaign which culminated in a June 9 election. Since 1940 Doctor Brown has also devoted hours of his time to Crippled Children and Adults and Easter Seal drives.

KENNETH L. KRABBENHOFT, M.D., DETROIT,

is new chairman of the Department of Radiology at WSU and is also new chief of radiology at Detroit General Hospital, a major teaching affiliate of the WSU medical school.

M. A. HOFFS, M.D., LAKE ODESSA,

who retired Dec. 31, 1968, after 40 years of active practice, was honored by his fellow Lake Odessa residents with a "Day of Recognition" late in May and a public reception at the Lakewood High School in Lake Odessa.

ADAM E. GAMON, M.D., SAGINAW,

formerly a private practitioner, has taken a position with the Disability Determination Service, Office of Vocational Rehabilitation, Lansing.

SIDNEY R. MICHAEL, M.D., FLINT,

July 1 began a new post as assistant clinical professor of medicine at the University of Wisconsin in Madison. He was a consultant in internal medicine at Hurley and McLaren General hospitals and former president of the Flint Academy of Medicine.

MARTIN L. BEARD, M.D., FLINT,

accepted an award recently in Minneapolis for submitting the outstanding manuscript published in *Minnesota Medicine*, the official publication of the Minnesota Medical Society. His article is entitled "Coarctation of the Aorta in Veterans."

LEWIS L. STEWART, M.D., JACKSON,

is new chairman of the Essex-Creglow-Cascades Area Improvement Association of the central Michigan community. The area improvement association is organizing monies to renovate the Cascades park in Jackson, a tourist attraction. Doctor Stewart is former president of the Jackson County Medical Society.

ARCHIE S. NAROTZKY, M.D., ISHPEMING,

is new president of the 21-member Board of Directors of the Michigan Epilepsy Center and Association, a voluntary agency supported by Michigan United Fund. Doctor Narotzky has been an Upper Peninsula general practitioner and surgeon for more than 25 years.

E. C. VONDER HEIDE, M.D., DETROIT,

one of the founders of the Michigan chapter, Arthritis Foundation, was recently awarded the foundation's Distinguished Service Award for volunteer service in the cause of arthritis.

W. G. GAMBLE, M.D., BAY CITY,

recently received a pin for 20 years of volunteer service with the Bay chapter, March of Dimes, at the Bay City Country Club during the chapter's annual meeting.

FRED L. HONHART, M.D., DETROIT,

83, a practicing physician for 52 years, was honored recently for distinguished service by Detroit's St. Johns Hospital.

SIDNEY A. BECKWITH, M.D., STOCKBRIDGE,

who has retired after 30 years of service to his community, was honored with a public reception given by townspeople at the Stockbridge American Legion Hall late in June.

JACKSON HONORS DOCTOR MEDLAR, DOCTOR AHRONHEIM

Jackson area organizations have recently honored two local physicians who are members of MSMS.

Robert E. Medlar, M.D., and J. H. Ahronheim, M.D., were recipients of Liberty Bell Awards presented to three of the community's active citizens at recent Law Day ceremonies in Jackson. Doctor Ahronheim has also been named Jackson County's Outstanding Citizen by the Jackson Interservice Club Council.

Doctor Ahronheim is founder of a citizens' organization called Operation Gentle Persuasion to promote human rights. He is a retired Foote Hospital pathologist and active member of the American Red Cross Board, American Cancer Society and Jackson County Medical Society.

Doctor Medlar is founder of the Jackson Area Drug Abuse Council, president of the Jackson Public Schools' Board of Education, active in the American Cancer Society, Red Cross and Jackson County and Michigan State Medical Societies.

IN MEMORIAM

Karl A. Anderson, M.D. **Grand Rapids**

Karl A. Anderson, M.D., Grand Rapids physician, died June 21 at the age of 79.

He was graduated from the University of Illinois and served on the staff of the Michigan Veterans' Facility in Grand Rapids. He was also affiliated with Blodgett Memorial Hospital in Grand Rapids. He was a general practitioner with special attention to psychiatry.

Howard J. Porter, M.D. Romulus

Howard J. Porter, M.D., a Romulus practitioner for 30 years, died May 20 in Fort Lauderdale, Fla., at the age of 70.

Doctor Porter was retired and was a graduate of the University of Geneva, Switzerland. He was affiliated with Romulus Hospital.

Simon P. L'Esprence, M.D. Detroit

Simon P. L'Esprence, M.D., Detroit gynecologist and heart specialist for 50 years, died June 5 at the age of 87.

Doctor L'Esprence was a 1912 graduate of the Detroit College of Medicine and was former chief of staff at St. Joseph's Mercy Hospital, Detroit. During the Depression he was chairman of Wayne County Medical Relief.

Ira D. Odle, M.D. Flint

Ira D. Odle, M.D., Flint general practitioner for 47 years, died June 11 at the age of 81.

Doctor Odle, a graduate of the University of Michigan Medical School, was the first intern to serve at Flint's Hurley Hospital. He was an emeritus member of the Hurley staff and was also affiliated with St. Joseph and McLaren General Hospitals in Flint,

Doctor Odle was a life member of MSMS and the Genesee County Medical Society and also belonged to the Association of American Physicians and Surgeons, the American Association for the Advancement of Science and the American Academy of General Practice.

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James R. Driver, M.D. Stuart M. Gould, Jr., M.D. Leonard E. Himler, M.D.*

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* 1904 - 1967

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MICHIGAN STATE MEDICAL SOCIETY **FUTURE ANNUAL SESSION DATES**

1969 - Detroit, September 28-October 3

1970 - Detroit, September 20-25

1971 - Grand Rapids, October 3-8

PONOTES & QUOTES 99

BY HERB AUER, EXECUTIVE EDITOR

"How can we blame the average kid for trying to destroy business,' asks Jerry Della Femina in the Marketing/Communications magazine. He continues: "In school the teacher who never worked at the business of business is telling him that all business is bad. On television he is exposed every night to United States Senators, like Magnuson, Hart, Nelson, Pastore, etc., grilling businessmen like they were common thieves. Their crime: make a profit. Their sentence, to be tongue-lashed and humiliated in public."

The use of time-sharing computers is booming in the nation and in Michigan. Time-sharing revenues will jump from \$80 million in 1968 to an estimated 3.5 billion per year in the early 1970's, according to Professor Gerald E. Nichols, Ph.D., in the current issue of the Michigan State University Economic Review. Professor Nichols reports that while Michigan had one time-sharing supplier in 1966, there are now seven. Suppliers have offices and call collection centers at Ann Arbor, Battle Creek, Benton Harbor, Detroit, Flint, Grand Rapids, Kalamazoo, Lansing, and Muskegon.

"I find the great thing in this world is, not so much where we stand, as in what direction we are moving."

- Goethe

"Association Newsletter," published monthly by Association Institute, a national clearing house, took note of the recent Desk Reference Cards on maternal health published in *Michigan Medicine*.

Said the newsletter: "upon updating its Desk Reference Cards on maternal health, the Michigan State Medical Society has enlarged their distribution. Each card deals with some aspect of obstetrics, such as prenatal care, infant resuscitation, etc. When MSMS began the service in 1962, the cards were supplied to a select list of doctors and to every hospital in the state which has a delivery room. The Committee on Maternal Health revised them last year and decided to give a set to every member. The new cards were bound into the February issue of *Michigan Medi-*



cine, and a fresh set was sent to the hospitals. One crucially important card, on oxytocics, was printed in red. The committee plans additional cards and will distribute them in the same way."

A San Francisco hospital is now charging obstetrical patients \$2.12-1/2 per hour for a semiprivate room. The charge used to be \$51 a day, which comes to the same thing, except that now they pay for only the used part of the day.

The latest study by the Dartnell Corporation reveals that the cost of the average business letter is \$2.74. This includes not only the cost of the postage, letterhead, and envelope but also the dictator's time, stenographic time, and overhead.

Projections about the labor force in 1975 interest physicians and hospitals as they look ahead at the labor market. Professor C. A. Myers of M.I.T. Sloan School of Management, reports the following changes based on projections by the U. S. Bureau of Labor Statistics . . .

1. There will be a 40 per cent increase in the age group, 25-34, the current group of teen-agers and young adults. Professor Myers says, "employers will have to tolerate considerable diversity in those they hire in the next decade."

2. There will be a 17 per cent increase in the age group of 55 and over, because of increasing longevity.

3. There will be a 30 per cent increase in the 15-24 group with more than ever in college, and a substantial increase in the youngerworker group.

4. There will be a decrease of 7 per cent in the 35-54 group, the prime age group.

Interested physicians may write to MSMS for the full article by Professor Myers from a recent issue of *Industrial Management Review*.

Alice Hamilton, M.D., a University of Michigan School of Medicine graduate who became the first woman to receive the U.S. Public Health Service Lasker award, celebrated her 100th birthday recently in Hadlyme, Conn., where she now resides. She was a pioneer in the industrial health field, was the first woman on the Harvard Medical School faculty, served as medical consultant to the Department of Labor.

Four more Michigan radio stations have added to their broadcast schedules the five-minute program, "The Human Side," developed and presented by MSMS Executive Director, Hugh W. Brenneman.

They are WIAA, Interlochen; WLDM-FM, Detroit; WKNR, Detroit, and WNMR-FM, Marquette. They bring to a total of 33 the total stations broadcasting this series on a five-day-a-week basis.

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The United Press International teletypewriter changed a story about a legislative committee when the teletypewriter keys punched away: "But a majority of the committee felt the entire bull should go to the floor."

LACTINEX TABLETS & GRANULES

■ to help restore and stabilize the intestinal flora

for fever blisters and canker sores of herpetic origin

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin. 1,2,3,4,5,6,7,8

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.



Baltimore, Maryland 21201

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References:

(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., 58:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, 25:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., 20:591-593, November 1965.

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When disease is ruled out and psychic tension is implicated

Valium[®] (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation

or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, atàxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcitec states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

AUGUST 1969 • VOLUME 68 • NUMBER 16

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Doctor Walt Sounds the Call to Detroit For Stimulating 1969 MSMS Scientific Session

All Michigan physicians should study the program and make their plans today to attend the 1969 MSMS Annual Scientific Session Oct. 1-Oct. 2 at the Sheraton-Cadillac Hotel in Detroit.

There they will find at close hand a stimulating variety of scientific topics being discussed all day both days by a roster of distinguished Michigan and out-state speakers.

Prominent among the offerings will be General Sessions, including two on current controversies in the use of marijuana and the sensational aspects of scientific reporting, as well as a series of short segments on the new developments in scientific subjects.

In addition, four all-day postgraduate courses, delving into Cardiovascular Pharmacotherapy, Medical and Surgical Emergencies, The Problems of Office Orthopedics and Nephrology Now will run simultaneously at the nearby Statler Hilton Hotel with the Scientific Session. Special offerings will include a moot court presentation, two general luncheons and the state society dinner dance.

Program chairman for the Scientific Session, Alexander J. Walt, M.D., here outlines the attractions of the 1969 program and urges all Michigan doctors to attend.

BY ALEXANDER J. WALT, M.D. PROGRAM CHAIRMAN 1969 MSMS ANNUAL SESSION

The 104th Annual Scientific Session of the Michigan State Medical Society will take place on the 1st and 2nd of October, 1969, and we hope that it will be well supported by physicians throughout our state.

The committee responsible for the general design and content of the meetings gave considerable thought to the purposes and objectives of this meeting in the light of modern practice and the changing needs of our membership.

Many circumstances were taken into consideration. With travel so rapid and so easy, many physicians tend to journey to national meetings or gatherings in far-off and glamorous places—but they see little of their Michigan friends and colleagues there. There has been a spawning of specialty meetings around the country which are well attended—but at these there is no opportunity to listen and talk to those working on the shared boundaries of one's medical interest. At the big meetings, there is virtually no opportunity to sit and have a detailed discussion with the participants about areas of special interest or difficulty—the size and atmosphere of our state meeting encourages this.

The usual program hews closely to the scientific line with little attention to the clamorous social issues which threaten to deafen us but which must be heard—these are best discussed at a state level and we have tried to provide this forum.

Our Program Committee has attempted to blend the scientific with the social, the lecture with the seminar, and to produce a mixture of the theoretical and the practical, the speculative and the proven. Participants on the program have been carefully selected in conjunction with the relevant specialty groups from all parts of the country. The Administrative Staff of the Michigan State Medical Society has devoted great efforts to ensuring that the meeting runs efficiently and comfortably.

Our committee hopes that our membership will support the Annual Program orally and physically and that there will be much more encouragement of residents and interns throughout the state to attend and see just how good an educational program Michigan is able to assemble. Exposure to the postgraduate and general programs may well bring recognition of what we have to offer here and a sense of pride which will induce these young physicians to make their professional homes in Michigan.

Register Now For All-Day PG Courses

Course Content

Cardiovascular Pharmacotherapy: 1969

Directed by: Park W. Willis, M.D., Ann Arbor Richard D. Judge, M.D., Ann Arbor

Invited Experts:

Walter M. Baird, M.D., Ann Arbor Richard J. Bing, M.D., Detroit Edward A. Carr, M.D., Ann Arbor James E. Doherty, M.D., Little Rock Leon M. Goldberg, M.D., New York City Henry H. Swain, M.D., Ann Arbor

Since William Withering, drug therapy has played an eminent role in the management of cardiovascular disorders. For the practitioner, drugs have been both boon and bane. Topics to be discussed in this symposium will include (a) digitalis therapy and intoxication, (b) the present status of beta-blockers, (c) effects of glucagon, (d) treatment of cardiogenic shock, (e) adverse cardiovascular effects of non-cardiac drugs, (f) iatrogenic arrhythmias, and (g) the use of lidocaine, procaine amide, and quinidine.

Medical and Surgical Emergencies: 1969

Directed by: Lawrence H. Power, M.D., Detroit Irwin K. Rosenberg, M.D., Detroit Program Being Developed.

Problems In Office Orthopedics

Directed by: Robert H. Ramsey, M.D., Dearborn Invited Experts:

Maxwell B. Bardenstein, M.D., Southfield Earl P. Holt, Jr., M.D., St. Louis, Mo. Lanney L. Johnson, M.D., East Lansing David C. Mitchell, M.D., Detroit

Musculoskeletal complaints are among the most frequent described by office patients. Here the practitioner will benefit from "curb-stone consultations" with the panel of experts who will discuss (a) cervical-brachial pain, (b) problems of the shoulder and elbow, (c) the fine points of hand surgery, and (d) gait problems in children.

Nephrology Now

Directed by: C. E. Rupe, M.D., Detroit D. A. LeSher, M.D., Detroit

Invited Experts:
J. R. Green, M.D.
William Oliver, M.D.
E. L. Quinn, M.D., Detroit

Common renal diseases, their diagnosis and treatment, will be reviewed and brought up-to-date. The technics of needle biopsy, hemodialysis, and peritoneal dialysis will be demonstrated, and discussions will be conducted of nephrotic syndrome, glomerulonephritis, pyelonephritis and the management of acute and chronic renal failure, providing opportunity to review conservative management as well as the indications for long-term hemodialysis and renal homotransplantation.

MSMS One Day Postgraduate Courses October 1 & 2, Statler Hilton Hotel

Enrollment Request:

Check course desired

Two courses to run simultaneously each day from 9:00 a.m. to 5:00 p.m. Registration is limited to the first 35 persons enrolling in each course. Course fee: \$10 per course.

Wednesday, October 1 (check one)	Thursday, October 2	(check one)
1. Cardiovascular Pharmacotherapy	3. Office Orthopedics	
2. Medical and Surgical Emergencies	4. Nephrology Now	
Name		
Address		
Check Enclosed		
Clip and Mail to MSMS, I	Box 152, East Lansing 48823	

Register Soon on First-Come Basis For Four Scientific Session Post-Grad Courses

The opportunity to delve deeply into four medical specialty topics will be given the first 35 physicians who register for the Postgraduate Courses being offered Oct. 1 and 2 concurrently with the MSMS Annual Scientific Session.

Registration is open on a firstcome, first-serve basis for the four

See Enrollment Blank, Page 868

all-day courses, to be located in the Statler Hilton Hotel in Detroit, near the Sheraton-Cadillac Hotel where the MSMS Annual Session will take place.

Registration fee for each of the classes is \$10.

Subjects of the four courses which will run from 9 a.m. to 5 p.m. Wednesday and Thursday are Cardiovascular Pharmacotherapy and Medical and Surgical Emergencies, both offered on Wednesday, and Office Orthopedics and Nephrology Now, on Thursday.

Cardiovascular Pharmacotherapy will be directed by Park W. Willis, M.D., and Richard D. Judge, M.D., Ann Arbor; with invited experts Walter Baird, M.D., Richard Bing, M.D., Edward Carr, M.D., James Doherty, M.D., Leon Goldberg, M.D., and Henry Swain, M.D.

The course will deal with drug therapy in the management of cardiovascular disorders and will include discussion of digitalis therapy and intoxication, the present status of beta-blockers, effects of glucagon, treatment of cardiogenic shock, adverse cardiovascular effects of non-cardiac drugs, iatrogenic arrhythmias and the use of lidocaine, procaine amide and quinidine.

Problems in Office Orthopedics will be directed by Robert H. Ramsey, M.D., and discussed by invited experts Maxwell Bardenstein, M.D., Earl P. Holt, Jr.,

M.D., Lanney L. Johnson, M.D., and David Mitchell, M.D.

Here the practitioner will benefit from "curb-stone consultations" with the panel of experts who will talk over cervical-brachial pain, problems of the shoulder and elbow, the fine points of hand surgery and gait problems in children.

Nephrology Now has been planned to review, and bring upto-date, common renal diseases and their diagnosis and treatment. Technics of needle biopsy, hemodialysis and peritoneal dialysis will be demonstrated. Sessions will focus on nephrotic syndrome, glomerulonephritis, pyelonephritis and the management of acute and chronic renal failure, providing

MDPAC Event Slates Congressmen

Two U.S. Congressmen from Michigan will headline the program of the annual MDPAC Breakfast, at 7:30 a.m. Oct. 1 at the Sheraton-Cadillac Hotel, Detroit, during the MSMS Annual Session.

The congressmen are U.S. Senator Philip A. Hart, and U.S. Representative Marvin L. Esch, Ann Arbor. Hart is chairman of the Senate committees on Energy, Natural Resources and The Environment and Anti-Trust and Monopoly Legislation. Esch is a member of the House Committee on Education and Labor.

Chairman of the breakfast is Louis R. Zako, M.D., Detroit. He will be assisted by Alexander Blain, III, M.D., Detroit; Donato F. Sarapo, M.D., Adrian; George L. Reno, M.D., Detroit; William Zimmerman, M.D., Birmingham; Robert Jardinico, M.D., Saginaw, and Mrs. Edward Weddon, Stockbridge, of the MDPAC Auxiliary.

the opportunity to review conservative management as well as the indications for long-term hemodialysis and renal homotransplantation.

Nephrology Now will be directed by C. E. Rupe and D. A. LeSher, M.D., Detroit, with a panel of invited experts consisting of J. R. Greene, M.D., C. P. Hayes, M.D., William Oliver, M.D., and E. L. Quinn, M.D.

At the time this article went to the printers the course description for the second postgraduate offering on Wednesday, titled Medical and Surgical Emergencies, had not come into MSMS Headquarters. Directors for the course will be Lawrence H. Power, M.D., and Irwin K. Rosenberg, M.D. The course program is being developed now.

Ample opportunity for informal, individual discussion with the panels of experts will be provided for all the doctors attending each postgraduate course. Question and answer periods are planned at the end of each course.

BETTER HEARING ASSOCIATION TO MEET

Post-Elementary Programs and Services for Hearing-Impaired Youth is the theme of the Michigan Association for Better Hearing and Speech's 38th annual convention planned Sept. 12-13 at the Jack Tar Hotel, Lansing.

Keynote speakers will be Robert Frisina, Ph.D., director of the National Technical Institute for the Deaf, Rochester, N.Y., and Edward C. Carney, specialist in the U.S. Office of Education, Washington, D.C.

G. Fred Moench, M.D., Midland, is immediate past president of the MABHS. Jordan C. Ringenberg, M.D., Grand Rapids otolaryngologist, is on the board of directors.

Wide Variety of Topics Offered for 1969 MSMS Scientific Session Oct. 1-2, Sheraton-Cadillac Hotel, Detroit

WEDNESDAY **GENERAL SESSIONS** OCTOBER MDPAC Breakfast - U.S. Sen. Philip Hart, U.S. Rep. Marvin Esch MORNING **GRAND BALLROOM** BALLROOM ANNEX SURGICALLY CORRECTABLE FORMS OF CURRENT CONTROVERSIES IN . . Moderator: Alexander J. Walt, MD, Detroit HYPERTENSION (Arranged by Section on Internal Medicine) Marijuana: Freedom or Control - Paul Lowinger, Moderator: Arthur W. Strom, MD, Hillsdale MD, Detroit; and Herbert A. Raskin, MD, Primary Aldosteronism - Jerome W. Conn, MD, Ann Arbor Physicians, Public Pronouncements and the Press: Pheochromocytoma - Albert Sjoerdsma, MD, Do We Need New Ground Rules: - Frank Chap-Ph.D., Bethesda pell, Dallas; and Donald R. Kahn, MD, Ann Renal Artery Stenosis - John R. Caldwell, MD, Endocrine & Renovascular Hypertension — Drs. Conn, Sjoerdsma, Caldwell LUNCHEON Luncheon — "The Black Physician and His Search for Talent" — Charles C. Vincent, M.D., Detroit AFTERNOON **GRAND BALLROOM** BALLROOM ANNEX NEUROMUSCULAR DISORDERS IN CHILDREN EFFICIENT USE OF BLOOD AND AND MINIMAL BRAIN DAMAGE AND ITS RE-**BLOOD COMPONENTS** LATIONSHIP TO MENTAL RETARDATION Moderator: Geoffrey L. Brinkmun, MD, Detroit (Arranged by Section on Pediatrics and Michigan Speaker: Harold A. Oberman, MD Ann Arbor Branch of the American Academy of Pediatrics) Panelists: John A. Penner, MD, Ann Arbor; and Moderator: George L. Blum, MD, Southfield Julius Rutzky, MD, Royal Oak Panelists: Richard Allen, MD, Ann Arbor; Tzvi OXYGEN — IS IT NECESSARY? Hart, MD, Detroit; and Leonard Graziani, MD, Panelists: Tom M. Johnson, MD, East Lansing; Philadelphia Thomas J. Petz, MD, Detroit; and Josef R. Smith, MD, Ann Arbor EVENING State Society Dinner Dance (Reception, Banquet, Dancing) THURSDAY **GENERAL SESSIONS** OCTOBER 2 MORNING **GRAND BALLROOM BALLROOM ANNEX** RELATIONSHIP OF MATERNAL NUTRITION WHAT'S NEW IN THE PRACTICE OF -TO FETAL DEVELOPMENT Chemotherapy of Cancer — Robert W. Talley, (Arranged by Section on OB-GYN) MD, Detroit Hematology - Scott N. Swisher, Jr., MD, East Speaker: Kamran S. Moghissi, MD, Detroit SEPTIC ABORTION WITH ENDOTOXIN SHOCK Allergy - Thomas E. Van Metre, Jr., MD, Balti-Speaker: Denis Cavanagh, MD, St. Louis Gastro-Intestinal Diseases - William S. Haubrich, MD. Detroit Infections and Antibiotics - Edward L. Quinn, MD, Detroit Rheumatology - Howard Duncan, MD, Detroit Pediatrics - William B. Weil, MD, East Lansing Diabetes - Fred W. Whitehouse, MD, Detroit Gynecology and Obstetrics - T. N. Evans, MD, Moderator: Neal A. Vanselow, MD, Ann Spor SPECIAL PROGRAM IN EAST ROOM ELEMENTARY DISCUSSION OF PROFESSION-AL INCORPORATION — A. Stewart Kerr, Detroit; David T. White, Detroit LUNCHEON Luncheon - Speaker to be Announced AFTERNOON **GRAND BALLROOM BALLROOM ANNEX BURNS AND SEPSIS DIABETES** (Arranged by Section on Surgery and Section on (In cooperation with the Michigan Diabetes Asso-Thoracic Surgery) ciation) Moderator: Irving Feller, MD, Ann Arbor Gut Hormones, Insulin and Glucagon - Roger Un-Panelists: Boyd W. Haynes, Jr., MD, Richmond; ger, MD, Dallas Glucagon - Newer Physiological and Clinical As-Thomas J. Griffka, MD, Detroit; James R. Lloyd, MD, Detroit pects - Piero P. Foa, MD, Detroit HIATUS HERNIA TEENAGE DRUG ABUSE

SPECIALTY MEETINGS

The following activities are listed alphabetically by specialty and not chronologically for the day:

Anesthesiology (4-5 p.m.)

Belladonna Drugs - Joachim S. Gravenstein, MD, Cleveland

Dermatology (10:45 through Luncheon) Malignant Melanoma - Diagnosis and Therapy -(Movie and Discussion) Earl J. Rudner, MD,

Detroit; William H. Beierwaltes, MD, Ann Arbor; Henry J. Vandenberg, Jr., MD, Detroit Gastroenterology (4-5 p.m.)

Bile Salt Metabolism and Liver Injury - James B. Carey, Jr., MD, Minneapolis

Internal Medicine (9-Noon)

See General Session Program for the Ballroom Ophthalmology (4-6 p.m.)

Fun with Ophthalmic Consulting - F. Bruce Fralick, MD, Ann Arbor

Otolaryngology (4-6 p.m.) Oral Lesions: Diagnosis and Management -William H. Saunders, MD, Columbus

Pediatrics (2 p.m. through dinner program) See General Session Program in Ballroom from

Dinner Program: Use of Electroencephalography and Clinical Evaluation for Assessment of High Risk and Low Birth Weight Infants - Leonard Graziani,

MD, Philadelphia Physical Medicine (2-5 p.m.) Treatment of Spasticity and Pain in Spinal Cord Injuries - Sedgwick Mead, MD, Vallejo, Cali-

fornia Plastic Surgery (11 through luncheon) Subcutaneous Mastectomy with Prosthetic Recon-

struction — Thomas D. Cronin, MD, Houston Hypospadias and Its Surgical Repair — Thomas D. Cronin, MD, Houston Proctology (2-3:15 p.m.)

Diagnosis and Treatment of Granular Proctitis -Richard G. Farmer, MD, Cleveland Public Health/Preventative Medicine (4-6 p.m.) The Epidemiology and Preventive Medical Aspects of Accidents - David Klein, Ph.D., East Lansing Radiology (4 p.m. through banquet)

Ultra Sound in Clinical Medicine - Douglas Gordon, MD, London **Urology (9-Noon)**

MD, Boston

Carcinoma of the Bladder — George R. Prout, Jr.,

Choice of Four All-Day Postgraduate Courses, Statler-Hilton Hotel

Enrollments are being accepted now for the four courses, \$10.00 each. Write MSMS, Box 152, East Lansing 48823.

Cardiovascular Pharmacotherapy Continuous From 9 to 5

J. E. Doherty, MD

H. H. Swain, MD Robert Talley, MD

C. M. Cohan, MD

W. M. Baird, MD

E. A. Carr, MD

Medical And Surgical **Emergencies** Continuous From 9 to 5

COURSE DIRECTORS: L. H. Power, MD I. K. Rosenberg, MI

COURSE DIRECTORS: P. W. Willis, III, MD R. D. Judge, MD **FACULTY:**

#3 Problems In Office **Orthopedics** Continuous From 9 to 5

COURSE DIRECTOR: R. H. Ramsey, MD FACULTY: M. B. Bardenstein, MD E. P. Holt, Jr., MD L. J. Johnson, MD D. C. Mitchell, MD

COURSE DIRECTORS: C. E. Rupe, MD D. A. Le Sher, MD FACULTY: J. R. Greene, MD Wm. Oliver, MD E. L. Quinn, MD

Nephrology

Continuous

From 9 to 5

SPECIALTY MEETINGS

The following activities are listed alphabetically by specialty and not chronologically for the day:

Allerygy/Applied Immunology (10:45-Noon) Immunotherapy of Ragweed Hay Fever — Thomas E. Van Metre, Jr., MD, Baltimore General Practice invited to all sessions

no special program **Neurology (2-3:15 p.m.)**

The Effects of 1-Dopa in the Treatment of Patients with Parkinson's Syndrome — George C. Cotzias, MD, New York Neurological Surgeons (4-5 p.m.) Business Meeting

Obstetrics and Gynecology (9-Noon) See General Session Program for the Ballroom Occupational Medicine (4-6:30 p.m.)

Oral Lesions Commonly Seen in Industrial Practice - Arnold B. Schaffer, D.D.S., Flint Orthopedic Surgery (4 through dinner) Stroke Rehabilitation - Vernon L. Nickel, MD,

Downey, California Pathology (10-5 including luncheon) Dermatologic (Non-neoplastic) Lesions — James H.

Graham, MD, California Psychiatry (4-10:30 through dinner program) Teenage Drug Abuse - Speaker, John C. Pollard, MD, Ann Arbor; and panelists, Adolpho J. Brane,

MD, Detroit, and Charles L. Wells, MSW, De-Student Dissent and Adult Response - Speaker, Robert Michels, MD, New York City, and panel-

ists, Morton Levitt, Ph.D., Detroit, and Mayer Subrin, MD, Detroit Surgery (2-5 p.m.) See General Session Program for the Ballroom

Thoracic Surgery (2-5 p.m.) Revascularization of the Myocardium - W. Dudley Johnson, MD, Milwaukee

> Make Detroit

With the Annual Session just a mouth away, all physicians are mged to make hotel reservations now so as to partake fully of the excelis planned.

Write or phone the Sheraton-Cadillac Hotel in Detroit and then mark your calendar for Wednesday morning, Oct. 1, through Thursday afternoon, the seond," MSMS officers urge.

The center pages of the July News Francismuch the program for the scientific neering. Details about other parts of the program appent in this and the Sentember is



Reservations Now

EVENING

Public Forum (Diabetes)

Moderator: Conrad R. Lam, MD, Detroit

nounced.

Panelists: William Silber, MD, (Surgeon) Cape

Town; W. Dudley Johnson, MD, (Surgeon) Milwaukee; Joseph Rinaldo, Jr., MD, (Gastro-

enterologist) Detroit; Radiologist to be an-

(Arranged by Section of Psychiatry and Michigan

Society of Psychiatry and Neurology, Michigan Dis-

trict Branch of the American Psychiatric Association)

Speaker: James C. Pollard, MD, Ann Arbor Panelists: Adolpho J. Brane, MD, Detroit; Charles

L. Wells, MSW, Detroit

For Physicians, Residents, Interns, Students - - No Registration Fee

Full Round of Events Set In Detroit For 1969 MSMS Woman's Auxiliary Convention

Wives of Michigan physicians will "Be Where the Action Is" when they accompany their husbands to the 1969 MSMS Annual Scientific Session Oct. 1-2 in Detroit.

Beginning with registration in the afternoon before, the 43rd Annual Convention of the Woman's Auxiliary to the Michigan State Medical Society will convene with that theme in mind Oct. 1-2 at the Pontchartrain Hotel.

General business meetings, special speakers, a film clinic, a live fashion show, the President's luncheon and the first annual MSMS State Society Dinner Dance at the Sheraton-Cadillac Hotel will highlight the women's program.

The schedule is as follows:

TUESDAY.

Sept. 30, noon to 4 p.m., registration

WEDNESDAY,

Oct. 1, 8 a.m. - 4 p.m., registration; 9 a.m. - formal opening, with keynote speaker, Mrs. John M. Chenault, president, Woman's Auxiliary to the AMA.

Noon – President's Luncheon, Live Fashion Show

2 p.m. — Meeting reconvened, guest speaker Stuart M. Finch, M.D., Chief of Children's Psychiatric Hospital, U-M, "Sexuality and the Teen-Ager."

3-4 p.m. – Workshops on Parliamentary Procedure, Home-

Centered Health Care, Legislation.

3-4 p.m. – Film Clinic 7 p.m. – Reception and MSMS State Society Dinner Dance, Sheraton-Cadillac Hotel

THURSDAY.

Oct. 2-8 a.m. to noon, regis-

tration; 9 a.m.—General Meeting, Guest Speaker, Leroy Augenstein, Ph.D., Chairman of Biophysics Department, Michigan State University; Introduction of New Officers

Noon – luncheon and musical interlude, husbands invited

Kathleen (Mrs. William G.) Mackersie 1897-1969

Michigan medicine has lost one of its most able and devoted members in the passing of Kathleen Mackersie on July tenth. She had served as President of the Wayne County and Michigan State Medical Auxiliaries, and was the only Auxiliary President to the American Medical Association from Michigan.

The wife of Dr. William G. Mackersie and mother of Joan (Mrs. Paul Dow) and Peter, she was a native of Canada and a longtime Detroit resident. Her world expanded into the national scene where her ability as a parliamentarian also brought her recognition.

A keen mind and a sense of humor, plus a meticulous sense of responsibility for detail, characterized Kathleen's many years of service, and a seemingly inexhaustible energy propelled her through her heavy schedules.

At times ill health necessarily curtailed her pace but her will to carry on dominated her life. In recent years, she and her husband traveled extensively and a summer home in Canada also served as a vacation spot for many years.

Kathleen's passing, at age seventy-two, leaves us with a feeling of Mission Accomplished and consolation for our privilege in having known and worked with her.

Winogene Darling (Mrs. Milton A.)

Michigan Medicine

MICHIGAN STATE MEDICAL SOCIETY

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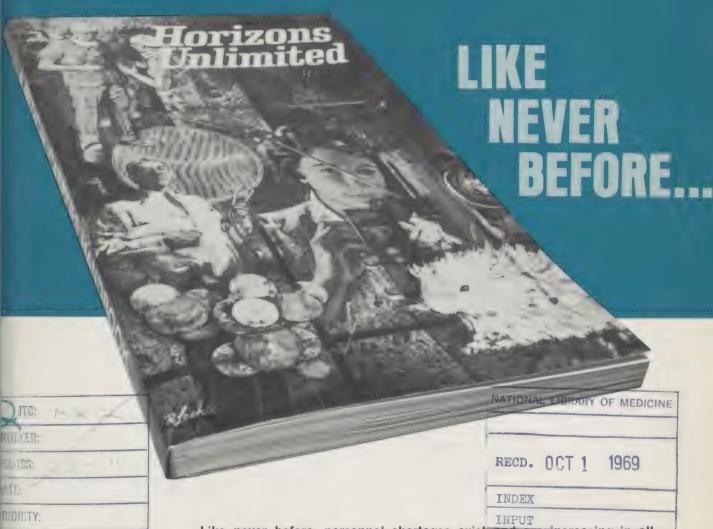
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MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

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PARTICIPATE IN THE 1969 MSMS ANNUAL SCIENTIFIC SESSION IN DETROIT, OCTOBER 1-2



Like never before, personnel shortages exist and are increasing in all the health services. And like never before, students, counselors, parents and the public are looking to the medical professions for leadership in meeting the coming crisis.

MSMS, with the cooperation of many other organizations, will focus attention on the health careers during the 1969 Community Health Week in October. Individual physicians are challenged to obtain the AMA handbook of careers, "Horizons Unlimited," from MSMS and join their county medical societies and MSMS in a concerted counseling project.



MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

SEPTEMBER, 1969 • VOLUME 68 • NUMBER 17

MSMS House To Install Mason, Select 16 Other Leaders

The election of the MSMS president-elect for the 1969-70 year will be one of the highlights of the annual House of Delegates meeting Sept. 28-30 at the Sheraton-Cadillac Hotel in Detroit. The elections will be Tuesday night, Sept. 30, in the Grand Ballroom.

Four delegate and alternate delegate posts to the AMA will also expire and be open for election. Current incumbents in these positions are: delegate — Otto K. Engelke, M.D., Ann Arbor; John R. Heidenreich, M.D., Daggett; Luther R. Leader, M.D., Royal Oak, and Robert E. Rice, M.D., Greenville; alternate delegate — Paul T. Lahti, M.D., Royal Oak; Harold A. Furlong, M.D., Pontiac; John W. Moses, M.D., Detroit, and Bradley M. Harris, M.D., Ypsilanti.

Also expiring this year are terms of office for MSMS Councilors — Sidney Adler, M.D., Detroit (first district); Ross V. Taylor, M.D., Jackson (second district); Harvey C. Hansen, M.D., Battle Creek (third district); Robert V. Daugharty, M.D., Cadillac (ninth district); Brooker L. Masters, M.D., Fremont (eleventh district), and J. Robert Franck, Jr., M.D., Wakefield (thirteenth district).

Elections will also be held for the speaker and vice-speaker of the House of Delegates.

Robert J. Mason, M.D., Birmingham, will be installed as new president of MSMS at a delegate dinner meeting in the Book Casino Room.

The elections will end three days of work by the House of Delegates, beginning on Sunday, September 28, at 6 p.m. when reference committee chairmen will gather for the Speaker's Dinner.

The Speaker's Dinner will be followed by the First Meeting of the House of Delegates. Ernest B. Howard, M.D., executive vice president of the American Medical Association, will bring greetings to the delegates. Also speaking at that time will be James J. Lightbody, M.D., Detroit, MSMS president, and President-Elect Robert J. Mason, M.D., Birmingham.

Other highlights of the First Meeting of the House will be the reports of the committees on Certificates of Commendation and Michigan's Outstanding Physician. The Outstanding Physician will be named and the Certificates of Commendation presented at the Delegates Dinner Meeting Tuesday evening in the Book Casino Room.

Delegates will consider resolutions and reports Monday and Tuesday. The Fifty Year Awards will be given Tuesday.



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Complete Summary Of Recent State Health Legislation; Pages 950-954

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Community Health Week Campaign To Focus on Youth in Health Careers

A drive to attract Michigan's youth to health careers will be the focal point of efforts by government leaders, agencies and associations in the health field and many public and community groups during the 1969 Community Health Week, Oct. 19-25.

"The time is ripe now to work on a broad health careers recruitment program," states Brock E. Brush, M.D., Detroit, MSMS Public Relations Committee chairman.

Doctor Brush kicked off the 1969 campaign by calling a brain-storming session late in July at MSMS Headquarters with leaders from 20 health and education organizations from around the state.

They gathered to suggest activities each of their groups might carry out in October and during the weeks preceding Community Health Week to draw the state's youngsters into health careers.

For, according to Michigan Health Council figures, Michigan must now recruit one of every 10 high school graduates each year into the health field to meet the state's needs.

John A. Doherty, MHC executive director, announced at the July meeting that Gov. William G. Milliken will take part in the Community Health Week promotion. He also revealed the tentative plans for an all-day Community Health Week Program set Monday, Oct. 20 at the Towsley Center for Continuing Medical Education at the University of Michigan.

The program is to include a welcome by Robert Mason, M.D., 1969-70 MSMS president, an address by a national speaker on health manpower, tours of University Hospital, the U-M Hospital centennial year observance and ap-

pearances by Gov. Milliken and U-M President Robben Fleming.

"It seems appropriate and logical that the 1969 Michigan Community Health Week effort concentrate on health careers," noted Doctor Brush to the leaders of the promotion who gathered at MSMS headquarters. "This recent legislative session, with the wide support for a four-year medical school at Michigan State University, has given more visibility to the need for physicians and allied health professions than any other short period of time.

"Agencies and associations in the health field and many public, community groups are all concerned about health manpower and quality health care. Competition is keen for high school graduates, calling for the combined efforts of the health team if we are to meet our need."

Community Health Week, which was started by the AMA on a national level in 1963, has been promoted in Michigan by MSMS, the Michigan Health Council and the Michigan Association of the Professions. Each year different topics, such as VD, quackery and careers, have been pushed.

Each interested Michigan organization this year will promote the cause of health careers through radio and television advertisements and programs, newspaper articles and editorials, speeches and programs before school groups and civic associations.

In addition the MHC, in cooperation with the American Hospital Association, is sponsoring a health careers poster contest for students from 6th through 12th grades. Winners will be announced at the Michigan Week program Oct. 20 in Ann Arbor by Gov. Milliken and will be eligible to



compete for national honors and cash prizes.

"The seventh annual observance of Community Health Week again affords members of the health team a splendid opportunity to demonstrate how we are "Teaming Up for Better Health," remarked E. Gifford Upjohn, M.D., president, MHC. The Health Council is making available a kit of promotional materials to any organizations interested in developing a Community Health Week project.

GENESEE DIABETES DAY NOW NOV. 5

The date for the fourth annual Diabetes Day sponsored by the Genesee County Medical Society in Flint has been changed from Oct. 29 to Nov. 5, according to chairman Paul Schroeder, M.D.

The all-day program, which begins with registration at 9 a.m., will take place at the Hurley Hospital Auditorium in Flint with luncheon provided at the hospital.

Observations about Reported Medicaid Payments to Doctors:

Communications to and from MSMS have followed the announcement in the press of large sums of money paid through Medicaid to a few Michigan doctors.

On July 9 sources from the U.S. Senate Finance Committee disclosed that 13 Michigan doctors collected more than \$50,000 each for treatment of Medicaid patients in 1968. Benton Harbor general practitioner, Sanford Polansky, M.D., topped the list with his bill of \$169,000 to Michigan Blue Shield for care of Medicaid patients.

The congressional committee was probing the names on the list to see how Medicaid costs to the nation could be reduced. In addition, a state legislative committee is investigating excessive fees paid some doctors and is also trying to find out how to cut costs.

The day the story broke — July 9 — Ross V. Taylor, M.D., Jackson, chairman of the MSMS Council, sent a telegram to all county medical society presidents to inform them that MSMS had officially requested federal officials to inform MSMS of alleged cases of wrongdoing so appropriate action, if any, could be instituted by the MSMS Judicial Commission and/or the component society.

"Component societies' presidents may be called for comment and ought to know the MSMS position," said Doctor Taylor in his telegram.

Louis F. Hayes, M.D., vice president for medical affairs of Michigan Blue Shield, also sent a telegram to all county medical societies notifying them that Blue Shield had not released the names of the doctors with high payments and that the presidents might be contacted by the press for their views.

Doctor Hayes followed his telegram with a letter reiterating the position that Blue Shield considers the identity of the doctors a confidential matter and did not release their names to the press. He emphasized that the doctors' payments had already been audited by Blue Shield and were in the process of being readjusted.

"It is most important to have a sense of perspective in this situation," wrote Doctor Hayes, "The function of the program was to provide quality medical care for patients who formerly could not afford it. The existence of the program has had that effect and . . . improprieties in frequency of services and patterns of charge have existed in no greater measure than we have experienced them before. It is, therefore, unjust for public officials to make sweeping condemnations and accusations on the basis of gross figures."

Earlier letters to MSMS from Blue Shield made it clear that the list of physicians' names, including all doctors who had received more than \$25,000 from Blue Shield in 1968, had been released only to the Michigan Department of Social Services, at its request.

Sen. Charles O. Zollar, (R-Benton Harbor) broke the story when he released a press notice that he would be conducting an investigation of the physicians.

MED SCHOOLS ENTERING MORE FRESHMEN

Twenty-four more entering freshmen are registered at Michigan's three medical schools than were registered in 1968, according to figures released by the schools.

Wayne State University has held its freshman enrollment steady at 130 since 1967. But at the University of Michigan, the number has jumped from the 205 registered in 1967 and 1968 to 225 for 1969. Michigan State University has increased its 1969 enrollment to 30 over its 1967 and 1968 enrollments of 26 entering freshman students.

Detroit Doctor Collects Baby Rattles; Will Display Them During Annual Session

While there is no formal MSMS art exhibit in Detroit during the Annual Scientific Session, the Detroit Institute of Arts will have on special exhibit the recently acquired collection of baby rattles, donated by Detroit pediatrician, Irving Burton, M.D., and his wife Doris.

Members and their guests are urged to visit this exhibit and the special Institute exhibits of photographic portraits by Yousuf Karsh.

In 1967 and again in 1968 a voluntary committee of physicians from the Detroit area in cooperation with the Detroit Institute of Arts arranged for art exhibits, open to the general public as well as to doctors and their guests, and housed in the Detroit Institute of Arts at the time of the MSMS Annual Session. The 1967 show concerned itself with the "Doctor Collects," and the 1968 show, "ARS MEDICA," offered more than 100 original prints of medical subjects from the collection of the Philadelphia Museum of Art.

The MSMS committee, reports Alfred Golden, M.D., plans to sponsor similar exhibitions in the future and would welcome suggestions and support from other MSMS members. Correspondence should be addressed to Doctor Golden, 26764 York Road, Huntington Woods, Michigan 48070.





Sen. Hart

Rep. Esch

MDPAC Breakfast October 1

"A prototype of the new young GOP breed" and the Democratic former assistant majority whip of the U. S. Senate will present timely discussions of interest to physicians at the annual M.D.-PAC Breakfast during the Annual Session.

U. S. Rep. Marvin Esch (R-Ann Arbor), a member of the House Education and Labor Committee, and U. S. Sen. Philip A. Hart (D-Mackinac Island), are the two scheduled to speak at the 7:30 a.m. breakfast Oct. 1 in the Woodward Room of the Sheraton-Cadillac Hotel, Detroit.

"Sensitive to the problems of the cities and the slums," commented Newsweek magazine of Mr. Esch, just nine months after he had gone to Washington. Esch is a former college professor and state representative.

He was a key figure in the Johnson administration's proposal leading to the Paris peace talks and had important parts on the Elementary and Secondary School Act conference committee and in legislation to require uniformity and equity in the Selective Service System. He is a member of the Western Alliances Task Force.

Sen. Hart is chairman of the Senate Subcommittees on Antitrust and Monopoly Legislation and En-

Vietnam Volunteers To Be Cited

Five Michigan doctors who have served with the American Medical Association's Volunteer Physicians for Vietnam Program will be honored at the Sunday night session Sept. 28 of the annual meeting of the MSMS House of Delegates.

Following a 6 p.m. dinner at the Sheraton-Cadillac Hotel, Detroit, the five will be presented to the House. Ernest B. Howard, M.D., executive vice president of the AMA, will address the group on behalf of the doctor's volunteer service.

The five are Hugh T. Caumartin, M.D., Detroit; Lambertus Mulder, M.D., Muskegon; Franklin V. Wade, M.D., Flint; Hugh L. Sulfridge, M.D., Saginaw, and Alfred B. Swanson, M.D., Grand Rapids.

Last year at the same time 11 other Michigan physicians who had served voluntarily in Vietnam were honored in a similar manner. A total of 19 Michigan doctors have worked in the southeast Asian nation. Virgilio Villarreal, M.D., of Flint is scheduled to go this fall, adding to the list.

A small exhibit on the AMA volunteer program will be displayed at the MSMS Annual Session Sept. 28-Oct. 2 in Detroit.

ergy, Natural Resources and Environment. He has been assigned to the National Commission on the Causes and Prevention of Violence and the Senate Select Committee on Nutrition and Human Needs.

He has been a senator from Michigan since 1958 and is former Lt. Governor of Michigan. He was elected assistant majority whip of the Senate in 1966 and 1967.

Michigan Medicine Presents New Monthly Feature

A new feature makes its first appearance on Pages 947-948 in this month's issue of MICHIGAN MEDICINE. Entitled "Governmental-Medical Care Programs," it represents another joint effort of the journal and the MSMS staff to provide current, vital information to Michigan physicians.

LANSING-AREA M.D.s, D.O.s SET FALL MEETS

The Lansing-area's unique program of lectures by visiting surgical professors to joint meetings of M.D.s and D.O.s is well-organized for the fall and winter.

Three all-day meetings of the combined groups have been scheduled through January, with speakers and topics lined up. The visiting physicians present evening lectures and are available for other local programs.

The schedule so far includes a visit Sept. 18 and 19 by Edwin Ellison, M.D., professor and chairman of the Department of Surgery, Marquette University Medical School, Milwaukee, Wis. He will present a lecture entitled "Non Beta Islet Cell Tumors of the Pancreas" at E. W. Sparrow Hospital. A Grand Rounds is scheduled at the hospital the following morning.

On Nov. 13 and 14 Lester Dragstedt, professor of surgery, University of Florida, Gainesville, will deliver a formal lecture on the evening of Nov. 13 and will be on hand for a planned program the following morning.

That will be the pattern also for the appearance of Rene Menguy, M.D., professor and chairman, Department of Surgery, University of Chicago, who will be in Lansing Jan. 8 and 9.



JAMES J. LIGHTBODY, M.D. PRESIDENT, 1968-69

See You In Detroit

The annual meeting of the Michigan State Medical Society is to be held in Detroit from Sept. 28 to Oct. 2, 1969. This is the 104th annual session of the Society and most of the meetings, particularly the House of Delegates and the Scientific Sessions and Exhibits, will be held at the Sheraton-Cadillac Hotel.

The meeting this year is being tuned to the times and there will be prominent, authoritative speakers on many current medical subjects, community and family interests and open discussions on these subjects will be invited. A tremendous amount of organizational work is involved in planning this annual meeting and one of the most difficult and time-consuming jobs is being Chairman of the Program Committee. Alexander J. Walt, M.D., of Detroit is Chairman of our Program Committee and he is Associate Dean and Professor of Surgery, Wayne State University School of Medicine. Doctor Walt and his Committee have incorporated sufficient diversity of subjects for presentation so there will be something of interest to attract every physician and his wife in the state to attend some portion of this convention.

Our House of Delegates will begin their deliberation at 8 p.m. on Sunday evening, Sept. 28. The worthy grand gavel pounder, Speaker of the House, James Blodgett, M.D., with the able assistance of Vice Speaker Vernon V. Bass, M.D., will referee the interlocutory verbal confrontations that emanate from the delegates. Ernest B. Howard, M.D., Executive Vice President of the American Medical Association, will speak to the House on Sunday evening.

The House of Delegates will meet again on Monday morning and the Reference Committees will meet on Monday afternoon and Monday night. The delegates will participate in the annual meeting of the Michigan Medical Service Corporation at 10:30 Tuesday morning and this will be followed by the Michigan Medical Service luncheon. The House will then reconvene at 2 p.m.

Tuesday for routine business and reporting of Reference Committees. The President's Dinner will be held at 6 p.m. Tuesday evening at the Sheraton-Cadillac Hotel when Doctor Robert Mason of Birmingham will be inaugurated and inducted, with appropriate ceremony, as the new President of the Michigan State Medical Society. Doctor Oliver McGillicuddy, a past president of the Michigan State Medical Society, will administer the oath of office to Doctor Mason.

Following the President's Dinner and inauguration, the House will reconvene at 8 p.m. for its final deliberations and also for the annual election of President-elect, Councilors and Delegates to the A.MA. All members of the Society are cordially invited to attend any or all meetings of the House of Delegates, including meetings of Reference Committees.

The scientific meetings and exhibits will begin at 9 a.m. on Wednesday and continue through noon on Friday.

The Woman's Auxiliary of the M.S.M.S. will hold all of their meetings at the Pontchartrain Hotel, starting on Wednesday with a breakfast at 7:30 and the first official session beginning at 9 a.m. Mrs. Roxie Weston, our very talented and energetic president of the auxiliary, will preside. The keynote speaker for the morning session on Wednesday will be Mrs. John M. Chenault, President of the Woman's Auxiliary of the American Medical Association and her subject will be: "Accent on Youth — Accent on You."

Among important activities on Wednesday morning will be a 7:30 a.m. breakfast sponsored by our M.D.-PAC organization at which time two distinguished Michigan Congressmen will be the honored speakers. Senator Philip Hart and Representative Marvin Esch will address the M.D.-PAC group and all doctors and their wives are invited to the breakfast and the program to follow in the Woodward Room.

The above line-up of events is just a fraction-ofthe-action that is planned for you – so we'll be seeing you in Detroit!

James J. Lightbody, M.D.





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- 2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size $(8\frac{1}{2} \times 11 \text{ inch})$ paper.
- 3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.
- 4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not
- 5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by Michigan Medicine. Michigan Medicine will pay the first \$25 of the engraving bill, and the authors shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.
- 6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.
- 7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.
- 8. Articles should ordinarily be less than four printed pages in length (3000 words).
- 9. References should conform to *Cumulative Index Medicus*, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.
- 10. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.
- 11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.
- 12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

Michigan Medicine

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

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- Clark D. Phelps, M.D., 540 Sixth Street, Traverse City 49684
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Patient comfort oncern

Patient comfort in chronic constipation is enhanced by restoration of normal pattern of evacuation.

- ☐ Gentle neuroperistaltic stimulation is mediated through the Auerbach's plexus in the colon
- ☐ Aids in rehabilitation of the constipated patient by facilitating regular elimination
- ☐ No laxative tolerance or rebound constipation reported in clinical experience
- ☐ Even many previously intractable cases have been successfully treated with SENOKOT preparations
 - ☐ Virtually free of side effects at proper, individualized dosage levels
 - ☐ Dosage may be gradually reduced and eventually discontinued in many cases, upon
 - restoration of normal pattern of elimination **Dosage:** (preferably at bedtime)—Adults: 2 tablets (max. 4 tablets b.i.d.). Children: (over

60 lb.) 1 tablet (max. 2 tablets b.i.d.). Supplied: Bottles of 50 and 100 tablets. Purdue Frederick
The Purdue Frederick Company, Yonkers, New York 10701

enokot Tablet

"Toward The New"

(Editor's Note: The following is an excerpt from the inaugural address by President Nixon.)

We cannot learn from one another until we stop shouting at one another — until we speak quietly enough so that our words can be heard as well as our voices.

For its part, government will listen. We will strive to listen in new ways—to the voices of quiet anguish, the voices that speak without words, the voices of the heart—to the injured voices, the anxious voices, the voices that have despaired of being heard.

Those who have been left out, we will try to

bring in.

Those left behind, we will help to catch up. For all of our people, we will set as our goal the decent order that makes progress possible and our lives secure.

As we reach toward our hopes, our task is to build on what has gone before — not turning away from the old, but turning toward the new.

-From President Nixon's Inaugural Address

To Attract The Young

"What should medicine do, both as individuals, and as organized societies about the problems that seem to discourage young men from considering the medical profession as a career?"

That question — and some possible answers — were provided recently by Dale L. Kessler, M.D., Grand Rapids, Chairman of the MSMS Committee on Medical Socio-Economics, in a report about a recent national meeting he attended for MSMS.

Doctor Kessler comments:

"What should medicine do, both as individuals, and as organized societies? Medicine cannot do nothing! Medicine cannot be reactionary! Medicine must provide leadership and responsibility in all aspects! Quality control is the most important phase the medical profession can supply. No other group is capable, but quality and economics of medical care are inseparable. Development of mutual respect, understanding, coordination and cooperation between the medical staff, hospital administrator, and boards of trustees is a must.

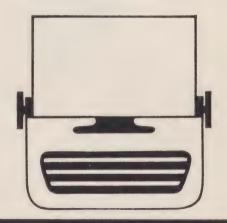
"Physicians must accept responsibility for the socio-economic aspects of medical care. There may be need to change some of the present organization in medicine, i.e., by geography or by specialty. Knowledgeable and interested physicians should represent organized medicine in these problems and should be reimbursed for their time by increasing dues to the medical society. We must develop methods on which to build a dynamic health care service which will fit our changing society."

Indiana Proposal

A suggestion that county medical societies have active "professional standards committees" is made by the Indiana State Medical Association President P. J. V. Corcoran in the current issue of the *Indiana Journal*:

"A local medical society should have a professional standards committee, appointed for the internal 'quality control' of its membership. It would be distinct from a grievance committee, which deals separately with problems external to the society. Any actual discipline in overt problems should be administered by the elected officers designated for this.

"A professional standards committee, for its part, would be entrusted with the responsibility of quietly and confidentially inquiring into any matter which potentially threatens the good name of a member or of the profession. It could avoid the untimely delay which is caused by waiting for written charges to be filed against the member, for by then it is often too late to achieve maximum good. As a committee, it can deal impersonally with matters that might be intolerably embarrassing for an individual to attempt to do for a colleague. I offer this to you for consideration and possible adaptation to your own locality."



EDITORIAL VIEWS



Editorial Note: This article is difficult emotionally to read. However, it should be read by all doctors, as well as social workers, nurses, school nurses and teachers. It is exceedingly important that it be read by those who have occasion to work in emergency rooms.

It is distressing to note that 27 percent of these children remained home with the abuser present without any supervision (the same percentage as were placed in foster homes). This is certainly neglect on society's part. Who is to blame? John W. Moses, M.D., Scientific Editor.

Child Abuse – Analysis of a Current Epidemic

BY MARILYN HEINS, M.D. DETROIT

INTRODUCTION

Child abuse is defined as "non-accidental physical attack or physical injury, including minimal as well as fatal injury, inflicted upon children by persons caring for them."

Child abuse is not a new problem. From ancient times infanticide by suffocation, exposure or drowning was an accepted practice even in such civilized societies as Greece and Rome. How the infant was done away with varied from culture to culture. The reasons for so doing also varied: malformations, multiple births, food conservation when supplies were scarce, and a method of what is today called family planning.

If an infant survived the natural and parental hazards of the newborn period to become a child, he still had problems. Under Roman law, for example, patria potestas gave the father absolute powers of life and death over his child. European law modified this concept to recognize that a parent or guardian had certain rights: those of custody of the child, control of his religious training and his education, consent to his marriage, the right of enjoyment of his services, and the right of chastisement. Evidently some parents chastised too hard and over the years courts have gained control over the parental power of chastisement.

In the early days of our country, Calvinistic beliefs dictated that a child should be whipped regularly in order to save him from his inborn evil spirit. Americans generally retain the feeling that parents have the right to discipline their children for their own good, whenever they see fit, without interference from others or the courts.

The author is director of pediatrics at Detroit General Hospital and assistant professor of pediatrics at the Wayne State University School of Medicine. In 1869, the New York Foundling Hospital was established to stop child murders by providing a refuge for unwanted children. This was one welfare attempt that was measurably successful: the child murder rate fell dramatically.

The first recorded case of child abuse occurred in New York in 1874.² A church worker calling on an elderly lady in a tenement learned that one Mary Ellen was brutally and frequently beaten by her foster mother. The child was malnourished, neglected and showed evidence of physical abuse. The church worker tried to remove Mary Ellen from her home but appeals to the Police and District Attorney were futile. She then appealed to Henry Bergh (who had founded the American Society for the Prevention of Cruelty to Animals in 1866) and convinced him that this child was being treated like an animal and certainly belonged to the animal kingdom.

The American Society for the Prevention of



SCIENTIFIC PAPERS



Fig. 1. Typical skin lesions caused by ironing cord and stick. (Detroit Police Department Photograph)



Fig. 2. Typical whip marks caused by ironing cord. (Detroit Police Department Photograph)

Cruelty to Animals brought action that resulted in Mary Ellen being removed from her home. A year later in 1875, the American Society for Prevention of Cruelty to Children was founded. Since then many child protective laws have been passed and child welfare agencies established.

MICHIGAN LEGISLATION

Michigan Act No. 98 (Public Acts of 1964) and Act No. 71 (Public Acts of 1966) require the reporting of suspected cases of child abuse involving a child under 17 to the State Department of Social Services. Those required by law to report include physicians, nurses, social workers, school principals, assistant principals, and counsellors. Reports are made on a form (#200) entitled "Confidential Report of Actual or Suspected Child Abuse" with copies sent to the prosecuting attorney, probate court, department of social services in the county in which the injury was inflicted and to the State Department of Social Services which keeps a central file in Lansing of all reported cases.

To facilitate complete reporting of child abuse, the law provides that any reporting party shall be immune to legal action that a parent or other person might initiate. Section 3 of Act No. 98 states: "Any person making or assisting in the making of the report shall be presumed to have

acted in good faith." These persons "... shall be immune from civil or criminal liability which might otherwise be incurred thereby." Further provision is made that "Neither the physician-patient privilege nor the privilege between spouses shall prevail in any action, civil or criminal, which is or may have been brought because of any report made pursuant to the provisions of this act. Any person who violates the provisions of this act is guilty of a misdemeanor." (Sections 4 and 5 of Act No. 98.)

CLINICAL PICTURE

The nationwide incidence of child abuse, its clinical, roentgenographic and pathologic picture have been well discussed in the recent literature^{1,2} as has the pathogenesis, i.e., the many postulated reasons why parents abuse their children. As with any disease, prompt diagnosis facilitates prompt treatment, which in the case of child abuse is removal of the child from his adverse environment. All doctors treating children and parents should be well aware of child abuse and of the fact that there are wide variations in the clinical picture.

Abused children are usually young, the majority being infants in one study,³ 30% three and under in another study.⁴ The history may be vague or may note specific trauma ("he fell off the bed,"

TABLE I

CLINICAL PICTURE OF CHILD ABUSE

HISTORY

Unexplained trauma Accident history inconsistent with trauma Accident history inconsistent with developmental age of child History of previous trauma

HEAD

Subdural Hematomas Cephalhematomas Intracranial bleeding

FAMILY

Young parents History of previous neglect or abuse of patient or sibling Social stress **Economic stress Emotional stress**

EYE

Subconjunctival hemorrhages Traumatic cataracts Retinal hemorrhages Papilledema

GENERAL CONDITION OF CHILD

Failure to thrive Developmental retardation Evidence of dis-turbed motherchild relationshin Autistic or de-

pressed behavior

BONES (X-Ray)

Fractures Periosteal elevation Eninhyseal separation **Abnormal** calcification

EXTERNAL EVIDENCE OF TRAUMA

Abrasions Bruises Burns Diaper rash Hematomas, ecchymoses Lacerations Soft tissue swelling Unusual rash Whip marks

INTERNAL EVIDENCE OF TRAUMA

Ruptured organs Masses (hemotomas) Renal bleeding

TARIF II

	INDEL	•		
	SEPT. THROUGH DEC. 1965 AND 1966	1967	1968	40 MONTH TOTAL
Child Abuse Cases Admitted to Detroit General Hospital	45	54	69	168
Cases Reviewed	42	54	68	164
All Pediatric Admissions to Detroit General Hospital	3713	2224	2004	7941
Percentage of Child Abuse Cases	1%	2%	3%	2%

"his brother pushed him off his bicycle," etc.) which may or may not be plausible in view of the injury. On the other hand the parents may seem oblivious to obvious marks of trauma and be able to give no explanation for the marks when they are pointed out. The children may exhibit evidence of poor care, failure to thrive, or actual malnutrition. There may be poor skin hygiene ranging from dirtiness through necrosis of skin in the diaper area. The child may exhibit irritability, diminished affect, frank autism or obvious fear of being approached by an adult. On the other hand, abused children may look and act like normal babies except for clinical (Figure 1 and 2) or roentgenographic evidence of trauma. (See Table I for a list of common findings).

DIAGNOSIS

How does one diagnose child abuse? First one must suspect it under any or all of the following circumstances:

- (1) trauma, especially in young children, without adequate explanation
- (2) "falls" in pre-walking infants
- (3) trauma in any child whose general condition is poor
- (4) repeated trauma in any child
- (5) X-ray evidence of old fractures at various stages of healing
- (6) head injury

(7) unexplained marks or rashes

In Detroit General Hospital if child abuse is suspected, the child is admitted to the hospital, a "kiddiegram" is done (X-rays of all bones and skull), social service and home nursing are alerted to make emergency home calls for evaluation of both home conditions and parental actions and attitudes. No child suspected of abuse is discharged without a decision as to his probable safety made by the pediatric, social service, and home nursing staffs working with the Wayne County Department of Social Services.

PRESENT STUDY

Since September 1965, when the pediatric department at Detroit General Hospital began reporting cases of Suspected Child Abuse to the Department of Social Services, State of Michigan, an alarming increase in the frequency of this "disease" has been noted. Totals have risen from 45 cases in the first 16 months of the study to 54 cases in 1967 and 69 cases in 1968. Extrapolation of current data indicates a still greater number of abused children will be identified in 1969.

Attempts to explain the rising number of cases on the basis of increased staff awareness of the problem since reporting became mandatory cannot be completely successful, because the admission rate to pediatrics had a simultaneous decrease (Table II).

		TAB	LE III		
SEX	Male	93	RACE		58
	Female	71		Negro	106
	Total	164		Total	164
AGE	0-11 mo	nths	62		
	1		16		
	2		19	120 (73%	
	3		13	of age a	nd under
	4		10		
	5		8		
	6		3		
	7		5		
	8		5		
	9 10		3		
	11		8 3 5 5 3 9 3 1		
	12		1		
	13		3		
	14		4		

TABLE	٧		
ОИТС	OME		
Died on wards Home — abuser in home Home — abuser not in home Placed with relatives Foster care		4 67 24 15 54	(2%) (41%) (15%) (9%) (33%)
		164	
FOLLOW-U	ID*		
Died (reabused)	1	(1%	.)
Home with abuser	10	(6%	
with supervision Home with abuser without supervision	45	(27%	,)
Home without abuser with supervision	3	(2%)
Home without abuser without supervision	26	(16%)
Living with relatives	16	(10%)
Foster care	45	(27%	
Unknown	18	(11%)
	164		
	May 1, 1 44 month		r abuse

	TABLE	IV	
TYPE OF ABUSE Beaten with hands Beaten with objects Bruises — manner unknown Burned Thrown against wall or floor Starved Bitten Smothered or choked Fed poison or caustic Hair pulled out Kicked Knifed Sexually molested Held under water Left out of doors in winter	72 40 37 22 20 15 4 4 3 2 2 2 2	WHO DID IT? Mother Father Sibling Stepfather Babysitter Grandfather Mother's boyfriend Aunt Uncle Foster mother Unknown * In one case both mother a father abused child	68 40 11 11 6 6 5 4 3 1 10 165*
AGE OF ABUSER 0-10 11-20 21-30 31-40 41-50 Total age known Age unknown	7 40 34 23 6 110 54 164	Of the 110 which the a abuser was 47 (43%) we under	ge of the recorded,

Analysis of cases of child abuse admitted to Detroit General Hospital since 1965 shows that there was a preponderance of male children involved; the ratio of Negro to white children was 2:1. The ratio of Negro to white at Detroit General Hospital is 3:1 indicating that more white children are abused than would be expected from the usual race distribution of pediatric patients at this hospital. (Table III)

The childrens' ages are shown in Table III. One hundred twenty out of 164 were four years of age and under. When the general condition of the

child on admission was noted on the hospital record, about equal numbers appeared well cared for as appeared uncared for (underfed, dirty, etc.).

Type of abuse is shown in Table IV. The total number of such acts is 227 as some children were unlucky enough to have more than one abusive act perpetrated on them.

Who abused the child and the age of the abuser are shown in Table IV. It is apparent in our series that mothers are the chief offenders and that abuse is often by young parents or relatives. In the 110

cases in which the age of the abuser was recorded, 47 (43%) were 20 or under.

Analysis of the outcome of the child abuse cases (Table V) shows that four died on our wards (all of head injuries), 15 children went home with relatives and 54 were placed in foster care. A total of 91 children (56%) went to their homes; 67 with the abuser still in the home; 24 with the abuser not in the home (example: a child was abused by his father but parents separate before the child goes home with his mother).

Follow-up as of May 1, 1969 from four to 44 months after the abusing incident reveals that one child died of re-abuse. He was properly identified as a case of child abuse but was murdered by his father before legal action could be taken. This case occurred in 1965, no deaths have occurred since, to our knowledge.

Sixteen children remained with relatives and were in good health at the time of follow-up. Forty-five were in foster care in good condition. Fifty-five children were at home with the abuser still in the home. Ten of these were being supervised by a social agency, but 45 were not. Interestingly enough, of these 45 unsupervised children still in the home with the abuser at the time of follow-up, several had been brought to medical attention again. One was re-abused and taken to another hospital. After we identified him as a previous case of child abuse, he was placed in foster care. Three children were readmitted to our hospital; one with a facial injury said to be (and considered to be) accidental, one with a vaginal discharge, one with a severe diaper rash and malnutrition. Still another baby was abandoned by his mother and is now in foster care. It was reported that one mother, living in another county, is still "cruel" to her children but no overt abuse has occurred. The remaining children were well without evidence of reabuse at the time of follow-up.

Twenty-nine (18%) children were at home without the abuser in the home, three being supervised by social agencies for poor home conditions (other than abuse) and 26 unsupervised. These children were apparently well at the time

of follow-up. Eighteen children could not be located for follow-up despite great efforts to do so. These children must be considered at risk of being reabused. In addition, all unsupervised children are at theoretical risk — both the 45 at home with the abuser and the 26 at home without the abuser. Re-abuse is a common problem in unsupervised or untreated parents,⁴ thus the children at home with the abuser without supervision might be injured again. Even some of the children at home without the abuser might be in danger of re-abuse, as a mother may decide to reconcile with the abusive father.

CONCLUSION

The physician's responsibility is two-fold. First he must recognize and report this "disease." As one doctor pointed out "the surgeon's opportunity to save such a child lies in his ability not only to treat the traumatic damage, but also to recognize the chronic and recurring nature of the underlying problems." Secondly, he should work within his community to bring about proper legislation to establish, and adequate financial support to maintain, child protective services. As Dr. Fontana says in his book *The Maltreated Child*, "We fail with leukemia; we fail with Hodgkin's Disease; but this is one childhood disease that is in our power to conquer." 2

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MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FIVE-WEEK PERIOD ENDING AUGUST 1, 1969

1969 1968 1969 1968 This Same Total Total 5-Week 5-Week To Above Same Period Period Date Date	Cases for 1968
Rubella 255 125 3,595 1,410	1,953
Measles 31 25 216 253	352 429
Whooping Cough 13 48 74 284	423
Diphtheria — — — — — — — — — — — — — — — — — — —	14,655
Scarlet Fever &	
Strep Sore Throat 398 572 6,183 7,041	10,101
Tetanus — 2 2	5
Poliomyelitis (paralytic) — — — — — — — — — — — — — — — — — — —	2 256
Hepatitis 247 246 1,815 1,256	2,356
Salmonellosis (Other than S. typhi) 60 71 287 399	614
Typhoid Fever (S. typhi) — 4 —	1
Shigellosis 21 48 168 154	346
Aseptic Meningitis 10 12 47 37	265
Encephalitis 11 4 58 52	114
Meningococcic Meningitis 7 6 89 63	94
H. Influenzal Meningitis 7 8 34 36 Tuberculosis 189 263 1,333 1,682	64 2,647
7 4 5 5 6 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	5,351
Syphilis 388 523 2,595 3,297 Gonorrhea 1,713 2,061 10,280 10,340	18,153

Information can be supplied by the local health department on the local incidence of disease.

> R. Gerald Rice, M.D., Director Michigan Department of Public Health

Meniere's Disease: Notes from the Michigan Association For Better Speech and Hearing

BY JORDAN C. RINGENBERG, M.D. GRAND RAPIDS GEORGE W. FULLER, JR. EAST LANSING

Many patients are seen in the physician's office with the chief complaint of vertigo or light-headedness. Of the total number of patients seen with this complaint, relatively few have Meniere's disease.

In brief, the disease is episodic with attacks of severe, disabling symptoms, followed by remissions in which the patient feels perfectly well. The most outstanding feature of the attack is an episode of acute severe vertigo in which the environment spins around the stricken individual or in which he feels he is falling in one direction or the other. When lying down, the patient feels that his bed is sinking away from him. This vertigo is so severe that it prevents walking. Any type of motion will aggravate the individual so that he tends to lie in bed in one position which is usually lying on the sound or uninvolved ear.

The duration of the symptoms may be from a few minutes to several hours. Accompanying the attack of vertigo is usually profuse perspiration, nausea and often vomiting. After the acute symptoms have subsided, the patient feels unsteady for a few hours or as long as two or three days.

During the attack, there usually is a sense of fullness or pressure in the ear and there is usually a buzzing or roaring type tinnitus. The hearing is muffled or decreased in most instances in the involved ear. Low tones of hearing are usually decreased most and there is distortion of loudness which results in a sense of discomfort or pain from loud sounds and of pitch which results in distortion of sounds. This distortion tends to make

Doctor Ringenberg is an otolaryngologist in private practice in Grand Rapids, where he has been active in the development of the Grand Rapids Hearing and Speech Center. Mr. Fuller is an audiologist with the East Lansing head-quarters of the Michigan Association for Better Speech and Hearing.

music and voices unpleasant and cause a loss of ability to discriminate speech satisfactorily. In a typical attack, the pressure and hearing symptoms begin before the onset of vertigo and warn of a beginning attack. The symptoms tend to peak during the active stage of vertigo and gradually decrease.

The first attack of Meniere's disease usually takes the patient completely by surprise. Recurrences may come at intervals varying from a few days to several years. Often there is complete remission of all symptoms during the early stages of the disease. With repeated attacks, residual tinnitus and hearing defect are apparent during remissions, the episodes of vertigo lessen or cease leaving the patient with tinnitus but without fear of recurrent vertigo. Meniere's disease is thought to be bilateral in 10 to 20% of cases. There are reports in literature that imply the bilateral disease of two ears usually comes within a short interval of time. The term Meniere's disease has often been used loosely and inaccurately to apply to any case of labrynthine vertigo. The pathologic lesion of the disease described by Meniere is now known to be a dilatation of the cochlear saccular and sometimes utricular endolymphatic spaces. Therefore, the name endolymphatic hydrops is less likely to cause confusion than the term Meniere's disease.

DIFFERENTIAL DIAGNOSIS

A typical case of endolymphatic hydrops concists of recurring vertigo, nausea, vomiting and ataxia, a unilateral fluctuating sensori-neural low tone hearing loss, diplacusis, distortion of sounds, tinnitus, and impaired speech discrimination. There is no other form of sensori-neural hearing loss with these symptoms; however, acoustic neuroma and multiple sclerosis should be ruled out.

AUDIOLOGIC IMPLICATIONS

While audiologic testing is of secondary importance in the diagnosis of Meniere's disease,

there are some important audiologic symptoms that should be noted. Unlike most sensori-neural losses, the loss associated with this disease is characterized as being of moderate degree and showing a flat slope configuration across the range of frequencies normally used in puretone testing. Speech discrimination during the acute or active stages is markedly depressed. However, in the arrested stage, speech discrimination is usually within normal limits at comfortable loudness levels (forty decibels above thresholds). Diplacusis is usually present in the active stage. Because this loss is peripheral in nature, Jerger's battery for differentiating between peripheral and central losses may be useful in cases where there is a multiplicity of physical symptoms.

TEST	PERIPHERAL	CENTRAL
SISI	positive	negative
Alternate Binaural	partial or	
Loudness Balance	complete	absent
Bekesy	Type II	Types
-		III or IV

The above chart lists the tests included in the battery and shows how the test results are reported for each site of lesion. In addition, various distorted speech tests may be used in this type of differential diagnosis. These tests will usually be interpreted by the audiologist in his report.

In summary a patient suffering from Meniere's disease may be thought to have the following audiologic symptoms:

- 1. A moderate hearing loss with a flat slope configuration, possibly more depressed in the lower tones.
- 2. markedly depressed speech discrimination during the acute or active stages of the disease.
- 3. normal speech or mildly depressed speech discrimination at comfortable loudness levels

- (forty decibels above threshold) during the arrested stages.
- 4. recruitment, either continuous or complete may be present.
- 5. diplacusis may be present.
- 6. differential diagnosis should indicate the presence of a sensori-neural loss.

As in all cases involving pathologic dysfunction, there may be some exceptions to the findings. It should be stressed, however, that audiologic tests are only a tool which the physician may use to confirm his own diagnosis.

TREATMENT

The treatment for Meniere's disease is either medical or surgical. There are a multitude of medicines used in the treatment of Meniere's disease, these consist of sedatives, motion sickness drugs, diuretics, histamine drugs and autonomic blocking agents. The Furstenberg low sodium diet is also used in conjunction with medication. The surgical procedures are generally divided into two groups. The first group of surgical procedures are those which tend to relieve the vertigo and maintain or improve the hearing present. These procedures are sacculotomy in which a small pick is inserted through the footplate of the stapes to cause fistulization of the saccule. There is also another procedure in which a small tack is inserted through the footplate into the vestibule and left in place. The theory of this procedure is that as the saccule expands with and increased amount of endolymphatic fluid, it will be reptured by the point of the tack. Ultrasound has been used successfully by some in the treatment of Meniere's disease. The second group of procedures consist of destructive procedures which consist of various surgical approaches to the internal ear and result in destruction of the membranous cochlea and labyrinth.

Raptus: A Neglected Psychophysiological Phenomenon

BY GORDON R. FORRER, M.D. DETROIT

The word "raptus" is the past participle of rapere—"to snatch or to seize." The word "rapt" means (1) carried away in body or spirit as to heaven; (2) carried away with joy or love as in "enraptured"; (3) completely absorbed or engrossed; (4) resulting in or showing rapture.

It was with these definitions in mind that I have chosen the word "raptus" to designate a previously neglected phenomenon observable to a varying extent and degree in all men, but especially prominent and significant in a wide variety of psychopathological states.

I observed, as you yourself no doubt have done, that from time to time for no obvious reasons individuals may start "woolgathering" or "daydreaming," or, as we sometimes say, "be in a brown study." Typically, the subject becomes silent and withdraws his interest from external objects. The usual small associative movements of the waking state diminish or cease altogether. The eyes are staring and unblinking and seem glazed and unseeing; an impression sometimes heightened by the apparent widening of the palpebral fissures. Invariably the gaze is fixed in the direction of the subject's front. His perceptive capabilities are blunted while at the same time he maintains an awareness of his surroundings. To the observer he appears to be in a state of psychological suspension. He ceases to relate emotionally with others. There is no identifiable content to the subject's thoughts. He is, at most, able to discern within himself a preoccupation with a mildly pleasurable sensation which he cannot describe. A great many people feel guilty in succumbing to the temptation to experience such states of being and a surprisingly large number recognize that in some way they cannot define, that "raptus" has a pernicious effect upon them.

INDIVIDUAL 'RAPTUS' DESCRIPTION

When I asked a healthy young girl to tell me as much as she could about her experience with raptus, she replied,

"You start thinking about something and then you aren't looking at anything in particular. Pret-

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ty soon you aren't thinking of anything and you're just in this trance and if someone tries to get you out of it—like if they wave their hand in front of your eyes you know they are doing it. You know where they are but you don't want to come out of it. It's comfortable. It feels good and you know you can come out of it any time that you want to. You come out of it when you know you have to do something—like when you are in class and you know you've got to come out of the trance and pay attention. Or, if you speak, that breaks it"

In contrast to the infrequency of occurrence and the evanescence of raptus in normal people one finds that the emotionally disturbed frequently indulge in raptus for prolonged periods. Moreover, there appears to be a direct relationship between the extent of involvement in raptus and the severity of the subject's psychological impairment. The immobile catatonic schizophrenic staring vacantly into space with fixed gaze seems to have withdrawn into a constant state of raptus. Considering the remarkable similarity of the raptus experience in normals and the subjective sensations of catatonic stupor, it may be that the latter can best be described as an exaggeration of the former. The following case material illustrates the raptus experience of several patients.

SEVERAL 'RAPTUS' EXPERIENCES

"I can remember before I started coming here (for psychotherapy) I'd get a weird feeling like I was going to stare. 'Let's not sit here and think about this' I'd say, 'let's think of something else.' When eating with others I don't do it (raptus). It would happen when I'm driving home. My mind was on things troubling me and I'd stare straight ahead. I'd say 'uh-huh.' It bothered me and I knew it wasn't right (to do it) — like I was getting engrossed in something I shouldn't be engrossed in. It reminds me of a look my baby used to give me when I started feeding him. Just about the same thing, I think."

Mrs. C. reports having a "thick feeling" in her eyes. This has been present for many years and has been especially prominent during the times she found stressful. She observes that she does her housework, washing and ironing, etc., while captivated by this state of feeling. She cultivates raptus

though she, like the foregoing patient, feels anxiety and guilt about her self-indulgence. She does not blink her eyes for the duration of the "thick feeling" nor at such times does she focus her gaze on objects. She becomes psychologically detached as she mechanically performs her work.

Mr. O. is schizophrenic. I have told him that his staring behavior is called "raptus." He asks:

"Is raptus anything like day-dreaming?"

"It's the same thing," I reply.

"Then I'm in it a lot more than I'm out of it. I do it all the time. You remember my telling you my head feels funny—light-headed and really like I'll pass out or something? That week I called it a 'thick feeling.' I tried stopping it like you said. It's being a baby again. I notice I do this whenever I come to something unpleasant. It's a way I have—a kind of trick—of getting away from it all and yet still being there."

Miss L. reports on her experience with raptus.

"I do it (raptus) almost constantly. . . . When I'm sitting and listening to someone talk, I'll go into it. Every time I try to snap out of it I get so tired. It wore me out to break it up. Everything will be so calm when I do it."

One of my patients described raptus as being "a built-in tranquilizer." Another defined his experience as "my mind is empty — like I'm asleep with my eyes open."

Another relates that he always "takes a trip" when he listens to music and after a concert doesn't even recall what he has heard.

RESOLUTION DETERMINES OUTCOME

Once the raptus phenomenon has been recognized, once the benefit of its relinquishment has been experienced by the patient, a successful therapeutic outcome hinges on the resolution of the infantile wish to indulge in raptus. The following is an example of a schizophrenic woman's struggle to withstand the temptation to lapse into raptus.

"All the progress I'd make (as a consequence of foregoing raptus) has gone down the drain. The whole week I just let myself go. This week when having such a rough time I wanted to stare. I know I shouldn't have, but you just want to go off into a blank stare. That stare takes everything away. After a minute you don't remember any of that stuff, but I shook my head and would say something. I find it (raptus) happening more often. I look at anything and suddenly stare at it. It gives me a creepy feeling like this was wrong like I shouldn't be doing it - like I'm running away. I know that the minute I run away from things. I never do it (raptus) when eating. I don't like to eat alone - I like to sit and talk with someone. Then I won't do it. (raptus)"

If a patient can be encouraged to relinquish his indulgence in raptus, immediate and dramatic clinical improvement often occurs. I think it not unlikely that those "spontaneous" improvements one observes among the mentally ill are preceded by the relinquishment of raptus without this fact ever having been recognized by patient or physician. As a corollary, where the raptus phenomenon is not relinquished, the status remains static or worsens. Unfortunately, for our therapeutic ambitions, the raptus-prone person repeats this behavior even after he has experienced the benefits of forswearing it.

Recently, in investigating the psychodynamics of a persistently silent patient, I explored the possibility that unbeknownst to me she was experiencing raptus rather than talking. I described raptus to her whereupon she confirmed my suspicions that all along she had been engaging in its gratification and for this reason had been silent. Indeed, to her own surprise, she recognized that she spent most of her waking hours in this state! Her therapy is now progressing where before it had been at a puzzling standstill. The recognition of raptus as a silent resistance had made obsolescent the earlier wasteful necessity to wait idly by hoping that she would somehow begin to verbalize.

RAPTUS' PSYCHOLOGICAL MANIFESTATIONS

The psychological manifestations of raptus are remarkably reminiscent of an infant when nursing from his 3rd to his 9th month. These manifestations are quite different than those presented in the written descriptions of nursing infants with which we are familiar, and in which it is claimed that the infant "looks" at his mother's face while nursing. If one is attentive to the nursing infant he may see for himself that the child is not "looking" at all, but is displaying the specific phenomenon of raptus. His eyes are unfocused, staring, unblinking, and have a trance-like hypnotic gaze. This differs substantially from the perceptive awareness evident in one who is "looking."

On each occasion of nursing during the earliest week of life one observes that the infant's eyeballs roam randomly under half closed lids and, psychologically speaking, he relinquishes whatever contact he has established with objects outside himself. This phenomenon, for want of another term, I call "merging." During the third month the infant begins to abandon this response when he suckles. One can observe that a new phenomenon has been introduced which, in time completely displaces "merging." In contrast to appearing to have "gone out of this world" when he nurses, the maturing infant commences to stare open-eyed; his gaze fixed but unfocused when he suckles. The palpebral fissures are often noticeably widened and the customary blinking movements of the eyes are suspended. So fixed is this empty gaze that a hand passed in front of the infant's face through

his line of vision does not distract him. One readily recognizes that this behavior closely parallels the phenomenon I described in adults as "raptus." In my judgment the phenomena are substantially equivalent. The raptus I described in adults seems to be nothing less than the retention of the specific infantile psychophysiological response so prominent between the 3rd and 9th months of life when the infant suckles.

RAPTUS IN ADULTS

Raptus in the adult is most likely the manifestation of a persistent unconscious wish to return to the suckling situation of infancy. It "says," "I am once more experiencing the comforting pleasure I knew so well in my mother's arms." What evokes this imprinted, non-verbal affective recall of the nursing experience? What causes it to pass quickly in the normal and persist in the abnormal? Except to recognize that the answers are to be found in the general area of the hunger-satiation axis, nothing definitive is presently known. As physicians our first work is to relieve the sufferer. But how should one proceed in treating those who are pathologically enmeshed in the raptus phenomenon? Conscious control over engaging in raptus is quite possible and unbelievably therapeutic strides accompany relinquishment. Where I find clues that a patient is indulging in raptus, I make inquiry concerning its form and specific manifestations. I explain to the patient what raptus is and inform him that it represents an "indulgence" in infantile gratifications. I attempt to enlist his cooperation in renouncing the habitual infantile wordless preoccupation to which he has become addicted.

IN SUMMATION

I have applied the term "raptus" to a universal psychophysiological phenomenon observable in all nursing infants and subsequently in a wide range of psychiatric difficulties. It is not the occurrence of raptus *per se* which has psychiatric significance, but rather the manner in which the experience is dealt with by the ego. The sensation of "being on a trip" and out of contact with reality is associated with a wide-eyed, staring and unfocused appearance of the eyes; the latter being fixed to the front.

Raptus represents a recapitulation of the preweaning nursing experience; a kind of wish-inbeing.

Psychotherapeutic benefit invariably follows when one who indulges in raptus foregoes this regressive egoless state.

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Personal Considerations From the AMA Rural Health Conference

BY DONALD R. McCORVIE, M.D. CHAIRMAN MSMS COMMITTEE ON RURAL MEDICAL SERVICE

I found the AMA 22nd National Conference on Rural Health held in Philadelphia on March 21-22, 1969 very interesting and informative and at times rather disturbing.

It is an established fact that there is a severe shortage of physicians throughout the United States both in metropolitan areas and rural areas of our country. Medical schools are just not keeping pace with the physicians we need, both in specialized areas and in family practice. The problem in the United States today is how to make available a greatly increased medical expertise to all of our citizens. Existing medical schools are not greatly increasing the number of graduates but there are a few new medical schools which are in the developing stages in an attempt to provide more new graduates.

Another serious problem is how does one get a young new physician to establish practice in a rural area.

For years there has been an influx of all people from the rural areas into the urban areas including physicians. New graduates from medical schools just do not want to practice medicine in a rural setting. Many of the wives of the physicians absolutely refuse to live in the country away from cultural pursuits, entertainment and good schools.

The graduating medical students of today know the income of rural physicians is comparable with that of the city physician so this is not a deterrent. They are more concerned with poorer hospital facilities, longer hours of work and poor coverage of their practice when they are away.

ENCOURAGEMENT NEEDED

It was suggested at the Conference that a definite effort should be made to encourage admissions committees of the medical schools to recruit students entering medical schools from the rural areas, preferably men married to rural girls before entering medical school so as to remove the possibility of the medical student later marrying a large city hospital nurse who would subsequently refuse to live in a rural setting. After they are in medical school the young men should be given the necessary training to be good family physicians so that they will be able to provide comprehensive medical care to our rural people.

Greater emphasis on the behavioral sciences and family practice in the curriculum of medical schools should be made. Improvement of hospital facilities and emergency transportation systems would be necessary. Establishment of well planned medical facilities utilizing the concept of group practice may help to attract young physicians to enter rural practice.

One bright spot is the newly established specialty board in family practice. Medical schools around the country are showing definite interest in this new specialty and are beginning to formulate and encourage training programs for the family physician.

Special attention should be given to improve the efficiency of each individual physician. Many physicians today spend much time on services that a well trained aid could do equally as well. This brings in the new concept of utilization of paramedical help. It also brings in the interesting new aspect of the doctor-assistant. There have been established in many areas of the United States training programs to produce such an assistant and they have been recruited from medical corpsmen recently released from the military service. If properly developed they could provide a very valuable addition in providing health care to the people.

SUGGESTIONS FOR MICHIGAN

In specific reference to rural health in the State of Michigan, I would set forth the following suggestions:

- 1. Support and encourage our Michigan medical schools to develop Departments in Family Practice within the medical school and institute training programs to acquaint the student with the aspects of comprehensive family practice and health maintenance.
- 2. Encourage the Michigan medical schools to support and guide in the establishment of family practice residency programs in the community hospital.
- 3. Establish postgraduate educational programs involving all physicians now in practice to further improve their efficiency by the utilization of paramedical help.
- 4. Encourage the medical schools of Michigan to encourage and guide in the training of paramedical personnel, specifically the doctor-assistant.
- 5. Consider a health survey of the present medical facilities of rural Michigan so as to establish comprehensive health planning that may be set in motion in the future.

Anticipating Death from Cancer -Physician and Patient Attitudes

BY RONALD R. KOENIG, A.C.S.W. DETROIT

The question of whether a cancer patient should be told of his diagnosis remains unresolved. Attitudes of physicians are presently in a state of transition and no clear consensus seems to exist. The admonishment that this matter should be managed individually with each fatally-ill patient according to that patient's particular circumstances is of no help to the physician as he faces his dying patient.

If there is any agreement about the management of patients in such situations it is that the patient should never be deprived of hope. Starting with this principle, each physician goes in his own direction with some usually telling the fatally-ill patient his diagnosis (and general prognosis) while others rarely or never tell.

The weight of opinion in the professional literature seems clearly in favor of informing the fatally-ill patient of his condition. Few reliable guidelines are offered for the clinical management of communication problems which occur in the doctor-patient relationship when the patient is dying, although there is ample evidence that problems of communication are common and serious issues of concern.1 Since the patient has no experiential frame of reference to conceptualize his own death, the doctor must understand the way that the patient experiences his illness and thus his death. This occurs within the context of changes which the illness introduces into his life and has strong reference to his past life crises. The physician can be guided in the informational exchange by becoming cognizant of the way that each patient experiences the process of dying.

Our intention here is (1) to define the current practices and attitudes in the field of medicine on this question, as expressed in the professional literature, (2) to present a frame of reference which can help the physician who is caring for the fatally-ill patient to become aware of the particular meaning of death for the patients whom he treats.

To accomplish the first purpose the author has systematically reviewed 51 articles on the manage-

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ment of fatally-ill patients which have appeared in the professional journals during the past 20 years, 2-51

Data to accomplish the second purpose are drawn from close observation and involvement with 110 patients suffering from incurable cancer of the intestine. These observations form a part of a study conducted in the Oncology Department of Henry Ford Hospital, Detroit, Michigan.

ANALYSIS OF THE LITERATURE

Articles studied in the professional literature tended to equivocate. Often the same article gave many reasons for and many against telling the patient that he suffers from a fatal disease. It was difficult in many instances to determine whether the writer was in favor of or opposed to informing the patient that his condition was fatal. It was, therefore, necessary to systematically record each statement in favor of telling and each statement against. (Table I)

Almost one-half (24 authors) expressed the opinion (sometimes supported with empirical research) ^{14,29,32,33} that most dying patients eventually come to know their diagnosis, notwithstanding the best efforts to conceal it from them. Patients, the authors felt, were often able to draw accurate conclusions about their diagnosis and prognosis because they understood the meaning of their symptoms (increased tumor size, weakness, loss of appetite), knew that radiation therapy was used in treatment of cancer or they picked up subtle cues from what the physician did, or did not, say.

Three authors, in fact, expressed the opinion that failure to tell the patient his diagnosis was detrimental because such concealments were interpreted by the patient to mean that his case was hopeless. Eleven writers felt physicians and nurses were better able to help the patient if they could talk openly about his disease with him. Ten thought that failure to tell risked loss of the patient's confidence and incurred his resentment. Twelve found that patients were more cooperative and accepted treatment more readily.

SIXTEEN AUTHORS favored telling because they felt it improved their communication with the patient. It was noted that patients not told of their diagnosis were more inclined to become isolated (13 instances) from family and other social contacts. When both the patient and family were aware of the patient's condition 10 writers felt that both were better off and could support and encourage each other.

In 15 instances in the articles reviewed it was mentioned that patients became increasingly anxious and upset as medical treatment proceeded. Knowledge of their condition tended to ease their mind rather than cause increased upset. Six authors felt that patients were not upset to learn of their diagnosis and two felt that failure to tell increased the danger that patients would fall into the hands of quacks in their desperate efforts to learn what was wrong with them. Six felt that patients ought to be told because almost all wanted to know if the diagnosis was cancer.

PRACTICAL REASONS were given for telling the patient in 15 instances. These authors felt the patient should be given an opportunity to settle his affairs before he became too ill. Ten writers believed the patient should be informed so that he might participate in decisions that importantly affected his life. Eleven indicated that advising the patient of his condition gave him an opportunity to master his feelings and find new meaning for his life with heightened appreciation of nature, religion, education, etc.

Eight physician-authors felt that they must inform the patient as a matter of medical ethics. In five instances writers indicated that public information and public education would benefit from a policy of telling patients their diagnosis because secrecy increased the fear generally associated with cancer. Two writers felt it was less of a strain on medical staff to deal with people who were aware of their diagnosis and two felt that patients who knew required less medical care.

In 43 instances in the 51 articles examined the authors supported a general principle or gave a definitive reason why some or all fatally-ill patients should not be told of their condition. (See Table I). Almost uniformly these writers referred to the emotional anguish that patients can be expected to experience as a result of awareness that they have a fatal, incurable disease. Nineteen writers expressed the opinion that advising a fatally-ill patient of his condition caused severe emotional upset. Seven felt the patient spent the remainder of his life in fear and depression. This was directly contrary to the opinion of some of those who favored telling the patients. Those who favored telling took the position that often fear or depression quickly passed and that it was not difficult to sustain the patient's hope and optimism.

Four writers believed that telling the fatally-ill patient of his condition increased the risk that he would withdraw from treatment. Two felt the patient, if he were told, was more likely to go to

quacks. Two indicated that cancer patients did not want to know their condition. While three recognized that failure to tell the patient of his fatal illness caused him to withdraw and isolate himself from family and friends, they expressed the opinion that it was preferable and more comfortable for the patient to be so isolated. One writer indicated that telling may precipitate other medical troubles such as coronary occlusion. Two believed it to be harder for family members when the patient was informed and one felt patients who were aware that they were dying were harder to manage medically. One writer indicated that telling patients of their condition was harmful to public education because it increased cancer phobia and one felt telling increased the likelihood of suicide.

MANY AUTHORS described conditions under which one should inform the patient and conditions which contraindicated informing. (Table II) Most of the authors suggested the physician should take into account the patient's emotional stability or his preferences about being told. Conditions are often contradicted from one author to another or are so vague that they serve little help as guidelines. In five instances authors indicated the patient should not be told "if he does not want to know" and the physician was advised to determine intuitively whether the patient wanted to know or whether information about his condition should be concealed.

In managing the informational exchange between the doctor and patient ten writers suggested the information about the fatal nature of the disease should be conveyed to the patient slowly and in piecemeal. No writer suggested that the patient should be told bluntly and given all available information at one time. If the patient chooses to deny his diagnosis five authors advised that he should be allowed to do so.

Eight articles expressly noted that the patient should not be advised of his fatal condition in such a way as to eliminate hope. Most articles implied that it was important to assure that the patient did not despair. Many suggested that the incurable patient be advised that there were a variety of treatments which might improve his condition and extend his life. Some told their patients that considerable research was in progress which might perfect new treatments in time to save their lives. Others suggested that the patient should be told that there are on record many cases of unexpected cure.

DEATH AND THE PATIENT'S FRAME OF REFERENCE

It is apparent from this summary of the literature that great variety of opinion and practice exists among physicians on matters relating to fatal illness. Such variation suggests that there is considerable absence of clarity on the topic. Great-

TABLE I

REASONS IN FAVOR OF AND AGAINST TELLING AS REPORTED IN 51 JOURNAL ARTICLES

REASONS FAVORING TELLING	Frequency
Patients generally learn diagnosis	24
Knowing aids communication	16
Knowing, they can settle affairs	15
Knowing eases patient's mind	15
Informed patients are less isolated	13
Informed patients are more cooperative	12
Telling provides opportunity for new life mastery, enjoyment	11
M.D. can help informed patients more	11
Informed patient can participate in decisions	10
Informed patients and family can better share burden of illness	10
Deception risks loss of trust	10
Ethical reasons favor telling	8
Patients prefer to be told	6
Telling does not upset patients	6
Telling benefits cancer education programs	5
Failure to tell causes hopelessness	3
Informed patients require less care	2
Failure to tell drives patients to quacks	2
Informed patients less strain on medical staff	2
Total statements in favor of telling	181*
REASONS AGAINST TELLING	
Telling causes emotional upset	19
Telling causes chronic depression and fear	7
Telling increases risk of stopping treatment	4
Patients prefer to be isolated	3 2 2
Telling is harder on family	2
Patients don't want to know	2
Telling drives patients to quacks	2
Telling causes physical breakdown	1
Patients harder to manage when told	1
Telling harms cancer education programs	1
Telling increases suicide risk	1
Total statements opposed to telling	43*

^{*}From 51 articles appearing in professional journals between 1946 and 1966.

er understanding of the way that patients view their imminent death is necessary if useful guidelines for physician-patient interaction are to be drawn.

Today parents are better able to discuss "sex" with their children than they were a generation ago. There has been little change, however, in their ability to answer their children's questions about death. There are a variety of reasons why one taboo has eased while the other remains essentially intact. Death taboo remains relatively unchanged because parents know little about death, prefer to ignore the reality of death and fear that frank discussion of the topic may be psychologically damaging to their children. Similar reasons seem to constrain many physicians from telling their patients that they have incurable cancer.

THE DILEMMA of what-to-say does not arise because the doctor must discuss disease with his ill patient. The issue arises because the physician must, if he talks honestly with the patient about his illness, at least tacitly, discuss with the patient his death. The most commonly reported reason that physicians do not tell patients of their condition is the fear that patients may fall into despair, that they may lose hope, withdraw into impenetrable depression, may kill themselves or escape into

psychosis. Such developments are rare in our experience and not reported with any frequency in the literature. Gerle, et. al.,²⁰ report on the impact which the awareness of diagnosis has on the incurable cancer patient. Their findings fail to demonstrate that "bad adaptations" to cancer (in the social and emotional sense) are associated with awareness of diagnosis.

Many writers emphasized the importance of providing an opportunity for the patient to "accept his death." Acceptance of death (or any severe affliction) in the sense that the term has generally been used, is a vague and ethereal concept of little value for understanding human experience. It becomes important here to develop an operational and behavioral meaning of the experience of becoming aware of one's death as this occurs to patients through the process of dying. This may provide a frame of reference to understand what is to be conveyed by the term "acceptance of death," a frame of reference which can be helpful to the physician in caring for the fatally-ill patient.

The question of what (or whether) to tell the incurably-ill cancer patient is a question too narrow to cover the important issues involved. Understanding of such a complex problem is related to

TABLE II

CONDITIONS FAVORING AND COUNTERINDICATING TELLING AS REPORTED IN 51 JOURNAL ARTICLES

CONDITIONS FAVORING TELLING	Frequency
Tell if patient asks	7
Tell if patient is emotionally stable	3
Children may be told they are fatally-ill	1
Intelligent patients may be told	1
Only tell "brave" patients	'
Total conditions favoring telling	13*
CONDITIONS COUNTERINDICATING TELLING	
Never tell the emotionally unstable	5
Conceal information if patient doesn't want to know	5 5 4
If patient is incurable do not tell	
If patient does not ask do not tell	4
If old or otherwise ill do not tell If relatives object do not tell	4 3 2
If patient is not intelligent do not tell	1
If patient has colostomy do not tell	i
Children may not be told they are fatally-ill	1
Total conditions counterindicating telling	26*

^{*}From 51 articles appearing in professional journals between 1946 and 1966.

the depth of scrutiny we are prepared to give its many facets. Some efforts in the professional literature have been in the direction of shaping vague formulas and guidelines and admonishing how, and under what circumstances, the physician should tell the patient he has a fatal disease. Little is said about the process by which the patient becomes aware of his impending death. It is usually not true that the patient confronts the prospect of imminent death and the essential implications of his situation at the time he is told that he has a fatal, incurable disease. Although denial, as a psychological defense mechanism, is often employed by patients to cloud awareness of approaching death, a failure to assimilate such information is more complex than simple denial. Failure to assimilate death information occurs when the patient has been unable to experience his death as a process. Simply informing the fatally-ill patient cannot be relied upon to bring about this awareness of death. He must come to this awareness mainly through observing the day-to-day advance of the disease and its effects on his life.

THE EXCHANGE during which the patient is told he has an incurable disease is an event which has a transient, usually upsetting effect on the patient. However, in the course of this experience, the patient does not usually become clearly aware that he will die. We are referring here to deeper levels of awareness as such death awareness is related to the patient's view of himself. We are not referring to superficial awareness which is primarily public and conscious such as attitudes which might be expressed in response to a question, "what does death mean to you?"

The ways in which fatal, progressive disease affects the broad life experiences of the patient after

he is told he is fatally ill and before he dies are most relevant for understanding what it means to the patient to die. His changing perceptions of himself, his changing perceptions of the rest of the world and the shifts in his capacity to be actively involved in his familiar world, should be viewed as a process through which a fatally-ill person defines the meaning of death for himself. The product of this slowly developing process may be considered acceptance of death. Acceptance, in this sense, refers to a situation in which the patient's knowledge that he will soon die has intimate personal meaning and relevance for him. This is not to say that the attitude of the patient who has accepted the imminent reality of his death is one of serenity.

It is difficult, if not impossible, for a person to anticipate that he will no longer exist in a sense that is familiar to him. The idea of death as a condition, whether viewed as an irrevocable end, a severence of the future or as a transition to an eternal life, seems to be beyond the range of one's frame of reference and therefore it is not sufficiently palpable to receive sustained attention. Since, in memory, there is by definition only experience, there is no experiental basis for understanding death.⁵³

Patients with incurable cancer (and probably all persons who experience lingering fatal illness) seem to define their personal death in terms of their life. Particularly, they define their death in terms of changes that occur in their life during the course of their disease. With illness the usual routines of living are interrupted. For fatally-ill patients the day-to-day criteria for measuring themselves as effective individuals (ability to work, play, etc.) are altered by the symptoms of advanc-

ing disease. These changes are within each patient's experiential frame of reference and provide for them the basis for understanding the personal meaning of dying for themselves.

In the course of living most people seem to evolve a personal frame of reference for measuring their individual worth and effectiveness. It is difficult to shift from former standards which are made up of daily self-evaluations based on performance as a family member, employee, community member, etc. However, it is these evaluations which form the underpinning for each person's feelings of self-worth.

UNDER ORDINARY circumstances each day offers many opportunities for reassurance that one is worthwhile. Disabling limitations imposed by advancing disease strip away these familiar reassurances and cause the patient to see that he is losing his life. By this daily recurring process the patient defines his death. Increasing disability and loss of vigor, changes in physical appearance, and increase in symptoms of pain, nausea, etc., impinge upon the patient's capacity to work, to love and to play. The capacity for effective action in these many roles are the critical measure by which a person comes to understand what he interprets to be the meaning of his life.

The physical changes which result from progressing disease are primarily of medical importance. The effect of the changes on the patient's style of life, his close relationships, his expectations of himself, are the criteria by which the fatally-ill patient comes to know the meaning of his condition. Each patient acquires a uniquely personal understanding of his illness and from this his death. It is the effect of these changes which add a different dimension to the patient's daily experiences with his family or with his work and provide the experiential basis necessary to define the meaning of death. This becomes of medical importance in terms of the evolving physician-patient relationship.

With one patient the ability to love and be loved is critical, with another it is the capacity to work. With the third the factor of critical importance may have to do with the capacity to manage family affairs or take care of physical needs. In this sense, awareness of approaching death is related to one's life history. The issues which become critical in defining death during the course of disease are the issues which have assumed priority because of the patient's particular past life experiences.

WE CANNOT say then that people die as they have lived, but rather that they draw from the fabric of their life, standards and criteria by which they define the meaning of death for themselves. Some examples may clarify this point.

Mrs. W., a 32-year-old married mother of children ages two, five and ten, was found to have re-

current abdominal cancer six months after perineal resection with colostomy was performed for removal of a rectal sigmoid malignancy. Although intelligent, she described herself to be unsophisticated and stupid. Her father had been alcoholic and her mother supported the family by doing laundry. She felt her parents had not loved her because they failed to keep promises when she was a child and rarely disciplined her. Because of this, loving her children, keeping promises to them and disciplining them became important criteria by which she measured her worth as a mother. With her own children she was very firm, demonstratively affectionate and was careful never to break a promise. She felt guilty because she could not "be a woman to her husband," in the sexual sense.

After she learned of the recurrence of her disease, Mrs. W. found herself unable to discipline her youngest child. If she did not punish him she feared the child would see this lack of discipline as an indication that she did not love him. If she did punish him she feared that he would remember her punishment when she was dead and he would feel that she had not loved him. Symptoms of weakness and pain which limited her ability to act as mother and wife, she interpreted in similar terms. Her symptoms and her impending death were defined in terms of their effect on her capacity for action. The symptoms jeopardized her evaluation of herself as a good mother and wife who could meet her responsibilities to her children and spouse.

It follows from the above example that efforts to help the patient deal with the anticipation of death must begin with an understanding of the way that the idea of dying is manifest as an experiential reality in the life of the ill person. Very often past life crises determine which issues will have central importance to the patient in defining the meaning of death.

ONE PATIENT experienced an aspect of the meaning of her death in terms of revived feelings of jealousy and worthlessness. Early in her marriage a crisis had arisen because of her husband's infidelity. They had worked out this problem and enjoyed what both agreed to be a good marriage. When she learned of her fatal diagnosis she realized that her husband would probably remarry and, in fact, she believed he should. Her jealousy and fear of being replaced nevertheless caused her considerable unhappiness and depression. Her death assumed meaning for her in terms of her ability to maintain her husband's interest and love.

Another patient, a cab driver, became increasingly depressed as his illness advanced. Though he and his wife had enjoyed a good marriage there had been a time, early in their marriage, when they had been near divorce. At that time his mother-in-law had been critical of him because she felt her daughter had married below her social class since he was "only a cab driver." He went into business but failed and returned to driving a

cab. Success at his work became important to him as a measure of his worth. When the progress of the disease prevented him from working he again experienced feelings of worthlessness that were like those feelings that had occurred earlier in his life. When the patient was able to understand something of the origins of these feelings he was better able to put them into the perspective of his present situation and his mood correspondingly improved.

IMPLICATIONS FOR TREATMENT

The encroachments of fatal disease often, almost uniformly, revive old anger, fear and depression which may both inhibit the patient's ability to reach some resolution of his feelings about death and interfere with his capacity to benefit fully from medical treatment. The effect of such strains has not been accurately measured. Querido⁵⁴ has demonstrated that such factors may reduce the efficacy of medical treatment by almost one-half.

It becomes apparent that when the physician treats fatally-ill patients he must be cognizant of the emotional experience which is the process by which they come to understand the meaning of death. Because this awareness is usually a slowly developing process, often correlated with the advance of the disease, it is probable that information should be dispensed to the patient in small, regular, therapeutic doses. This should correspond to the patients' increasing capacity to understand and manage the idea of his death as he proceeds to define death for himself within the context of changes in his life and in terms of the feelings which are stirred by the crises of fatal illness.

The informational exchange should begin to occur, it seems, early in the course of the disease as soon as the physician is sure of the fatal diagnosis. The patient will then have an opportunity to begin the process before his energy is profoundly diminished and before symptoms too greatly interfere with his capacity for action.

Because of the complexity of the problems and their uniquely individual nature fatally-ill patients often require more time with their physician. It is not necessary for the physician to be experienced in psychotherapy but he must understand the essential questions which affect his patient. He must know something of the life issues, past and current, which impinge on the patient. With this understanding he can gauge his communication with the patient more confidently. The decisions of how much detailed information the patient may be given about his condition need not be made intuitively but decisions may then proceed from facts understood about each patient. Knowing what death means to a patient and helping him to deal with the anticipation of death requires that the physician know his patient well. This may sometimes be expensive in terms of the physician's

investment of emotion in the dying patient as well as his investment of time.

Often the physician must decide to bring in other expert assistance to help in the care of the fatally-ill patient. Occasionally psychiatric consultation may be necessary; more often the services of a medical social worker are needed. Decisions about such issues can be made judiciously if the physician has more intimate knowledge of the patient, his important feelings, and the personal meaning of his awareness of impending death.

ABSTRACT

Articles discussing the management of fatally-ill patients appearing in the professional journals during the last 20 years were systematically reviewed. The tendency of authors appears to be strongly in favor of informing the fatally-ill patient of his condition. A variety of reasons are cited which favor informing the patient. Much less frequently, reasons in opposition to informing the patient are cited. A frame of reference is presented to clarify the meaning of "adjustment" to fatal illness as patients experience recurrence of past problems within the context of their current stresses. Some implications for the management of fatally-ill patients are presented.

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Good Care, Exercise of Mind and Body Prevent Aging, Doctor Swartz Testifies

The AMA Committee on Aging, after 15 years of study, has come to the conclusion that there are no disease entities or physical or mental conditions that result from the passage of time, or aging.

The committee firmly believes, moreover, that no one can foretell that a specific condition can reasonably be expected to occur in anyone after the passage of a specific amount of time.

Frederick C. Swartz, M.D., Lansing, chairman of the Committee on Aging of the AMA Council on Medical Service, testified to the above findings before the Subcommittee on Health of the Elderly of the Senate Committee on Aging on July 18, 1969.

LESSEN IMPACT OF AGING

"From our point of view, a major way of reducing the impact of the economics of aging is to lessen the health hazards, to eliminate the concept that after 65 one is over the hill, and to provide the employment and motivation necessary so that the oldster feels wanted and useful," said Doctor Swartz during his talk entitled "The Health Aspects of the Economics of Aging."

"In addition," he continued, "we need an educational program for older people that would place proper emphasis on physical and mental exercise, on adequate but not over-nutrition, and on elimination of physiologic habits such as smoking. Further, the educational program should be supplemented by a positive health program for the healthy as well as for those with chronic conditions. This then, would reduce the incidence of chronic conditions and improve life expectancy."

In many medical articles, said Doctor Swartz, the terms "aging" and "aging process: are used interchangeably with the term "degeneration." There is a growing concept that these terms need more specific definition and some separation, he said.

"I am happy to report," said Doctor Swartz, "that in the past few years more people in the health field have begun to realize that all the signs and symptoms witnessed among the aging represent some functional aberration related to the presence of a chronic condition or the lack of proper physical and mental exercise."

The AMA Committee on Aging has been unable to find any disease entity that was of necessity related to the passage of time, said Doctor Swartz. Arteriosclerotic heart disease, high blood pressure, arthritis and cancer are found in the youngster, and measles, mumps, chicken pox and poliomyelitis are found in the oldster.

CARE OF 'CASTLE'

The individual frequently accords less than ideal care to "the castle in which he lives," noted Doctor Swartz, and he emphasized that many of the so-called infirmities of age stem from lack of conditioning.

Further, he continued, forgetfulness and mental retardation result largely from lack of attention, failure to concentrate and loss of motivation.

"This can largely be prevented if we will continue to encourage people of all ages to maintain the habits of study learned in school," he said. "We can prevent mental deterioration by helping older people to continue in employment. Some serious reading and thinking should be a part of each man's daily life. The muscles are strengthened and the wits are sharpened only by proper physical exercise and mental activity.

"Our whole program aimed at retarding the so-called 'aging process' by improvement of physical and mental activity would fall short of accomplishment if we did not at the same time strike a blow for moderation in the use of alcohol, tobacco and food," continued Doctor Swartz.

END TO CONDESCENSION

The medical and paramedical services must begin to realize that something can be done for diseases found among the oldsters, Doctor Swartz challenged his contemporaries. The days of condescension medicine to "grandpap and grandma" are at an end, he said. Age is no bar to good medical or surgical treatment including open heart surgery.

Doctor Swartz further challenged those in medical fields to recognize degrees of "wellness"; to devise and use more tests of organ function to go beyond the point of evaluating the presence or absence of chronic conditions.

"Thus far, our thinking has been largely disease-oriented," he commented. "If we persist in thinking along this line, there will be millions of well oldsters and well youngsters that will fail to get the attention they need to prevent them from falling heir some day to a chronic condition."

"Physical exercise and good posture, daily mental exercise — not a bread and butter kind — and careful regulation of body weight are essential for every individual," said Doctor Swartz. "If we do all these things, if we continue our immunization programs and if we add periodic health appraisal and positive health programs, life expectancy should increase by 10 years in one generation."

Minor Footnote To Michigan Medical History: The Lansing Strain of Poliomyelitis Virus

BY RICHARD D. BATES, M.D., F.A.C.P. LANSING

As children we used to play a wonderful game of State Capitol conundrums. I only remember two:

Q: What was the greatest physical feat?

A: Wheeling West Virginia.

Q: What was the greatest surgical feat?

A: Lansing, Michigan.

Several lesser medical feats, such as the development of the Kahn test for syphilis, have occurred in Lansing. But perhaps the city's widest medical fame came from a discovery made elsewhere from material obtained at an autopsy of a youth dying in Lansing's E. W. Sparrow Hospital.

UNTIL SOME SPOILSPORT renamed it Type II, the Lansing strain of poliomyelitis virus was well known as the first of the only three strains* ever identified; it was the first strain adapted to cheap laboratory animals and was the principal strain used by Enders and Weller** in the culture of polio virus on monkey kidney cells for which they shared the Nobel prize and from which the Salk and Sabin vaccines developed.

Recently, I became bemused with the question of whether the relatives of that youngster had ever been told of their—and his—contribution. Would it be possible to find the name of this one individual after 30 years, and would there be any relatives left? And how did it all happen in the first place?

Charles Armstrong, a senior surgeon in the Division of Infectious Diseases of the National Institutes of Health, then a department of the United States Public Health Service, first used the term "Lansing strain" in reporting the first culture of polio virus in a laboratory animal other

than the prohibitively expensive rhesus monkey. His article¹ begins:

"Through the courtesy of Dr. Max Peet, of the Department of Surgery, University of Michigan, we received on August 28, 1937, a sample of brain and cord from an 18-year-old boy, one of several cases of poliomyelitis which occurred at Lansing, Michigan during that summer."

The article goes on to relate that this material was inoculated into several species of rodents of which only the cotton rat, an unusual laboratory species, became infected. Further, polio material from two other sources did not infect the cotton rat. In fact, the Lansing material died out after the second transfer from one rat to another. But in 1939 Armstrong tried again with some material he'd saved and this time the virus adapted to its new host, gained in virulence and was passed serially through seven cotton rats. Brain and spinal cord emulsions from the second and fifth rats caused typical polio in monkeys, so there was no doubt about the nature of the infection. Not that there was much doubt in the first place: Armstrong's cotton rats were healthy for a few days after their injection, then developed roughness of their fur, jumped when stimulated and then developed paralysis of one or more legs. Several even developed all the signs of human bulbar polio. Furthermore, microscopic examinations of their brains showed changes identical to those found in humans.

ARMED WITH THIS INFORMATION, my first stop was with Sparrow's record librarian. Could she turn up a record of an 18-year-old male dying and coming to autopsy during the month of August, 1937?

No, but there was a 19-year-old whom I'll call Herbert Frank, although that is not his real name. The record left no doubt that he was, in fact, the source, because some meticulous secretary had placed in his clinical folder a 1938 letter of inquiry from one Max Peet, M.D., at the University of Michigan. According to that letter, a Charles Armstrong, M.D., of Washington was requesting a summary of the case.

Record #49991 was, by modern standards, unacceptably sketchy. It discloses that Herbert was admitted by his general practitioner, T. P. Vanderzalm, M.D., and seen by two interns. Perhaps because they were only two months out of medical

Doctor Bates is an internist in private practice in Lansing.

^{*}Type I or "Brunhilde" was named for a chimpanzee dying of an innoculation of material from seven human cases in Baltimore, Md., in 1939 and the "Leon" or Type III strain was named for a Los Angeles lad who died of polio in 1937.

^{**} Dr. Weller's father was famed Carl Vernon Weller, Chairman of Pathology at the University of Michigan and his grandfather was a general practitioner in St. Johns, Michigan.

school, their histories go into detail about the fact that Herbert had almost died of a ruptured appendix nine months previously, but fail to describe his present illness. They *did* note that other members of the family had recently been ill with poliolike symptoms but had recovered, and that he had first become ill on August 22. Two days later he was admitted to the hospital with a fever of 104°.

TWO DAYS AFTER THAT, at 11 a.m. on August 26, 1937 he stopped breathing. There was no tracheotomy, no respirator, no flurry of keeping the heart beating and lungs working by artificial means. In those days polio victims either recovered or died; medical science offered nothing beyond conventional nursing care. Nothing, that is, except an autopsy.

One of the two interns who had examined Herbert on admission was a Marion Belle Rood, M.D., unusual in that she was a woman then 39 years of age. She had just finished her medical school training at the University of Michigan where she fell under the spell of Max Minor Peet, M.D., professor of neurosurgery, and a man of such wide and enthusiastic interests that he is reputed to have nearly failed medical school because of a preoccupation with ornithology.*

In the mid '30's, Doctor Peet turned his attention to the problem of polio, which was of neurologic, if not neurosurgical, interest. He became enchanted with the theory that polio viruses gained access to the brain by travelling from the membranes lining the nose up the olfactory nerve, a distance of less than two inches. Accordingly, he experimented with the spraying of corrosive chemicals directly on nasal surfaces in hopes of temporarily coagulating the entrances to these nose-brain corridors. At first there seemed to be a ray of hope, but it failed when it became apparent that the effects were permanent and resulted in life-long loss of the finer components of taste and all smell. (As is now known, the virus goes first to the intestinal tract, thence to the blood stream and then to the brain, anyway.)

Doctor Rood knew of Doctor Peet's interest and that he wanted fresh brain material for culture from fulminant cases. Though but an intern, and a woman at that, her advanced age and fervor persuaded the acting pathologist, Milton Shaw, M.D., to alter routine autopsy protocol in two important ways: First, the brain was not cut or examined in Lansing (although it was the *raison d'être* of the whole autopsy), and second, it was dropped into saline and glycerine rather than the usual virus-killing fixative of 10% formaldehyde.

SINCE GLYCERINE ALONE would not prevent spoilage, she took the intact brain that very

* Many years later he successfully combined his two interests and identified a new subspecies of wild ducks on the basis of their skull X-rays.

night to Ann Arbor, 80 miles away, and delivered it to Doctor Peet. He had a neuropathologist perform the necessary examinations to document the changes of polio and then sped fragments to Doctor Armstrong in Washington where they arrived two days after Herbert's death.

Those were the facts pieced together from a medical journal and a microfilmed clinical record lying 30 years in dust. And there was the autopsy permit signed by both the father, William, and his wife; signatures remarkably steady for parents in anguish over the loss of a 19-year-old boy who had been in life-threatening jeopardy for the second time within the year and sick this time but four days.

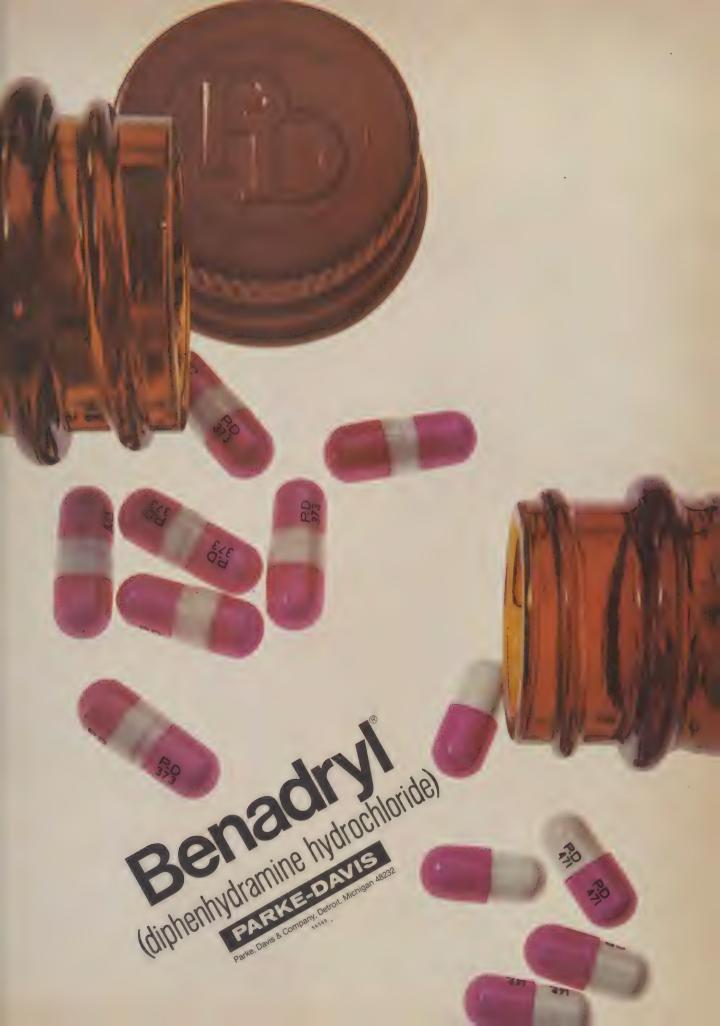
The next question was, were the parents or any other members of the Frank family available? Of the three Franks in the Lansing telephone book, the first had never heard of a "William" nor a "Herbert." The second had had his telephone disconnected but the third, Robert, was three when his brother Herbert died of polio in Sparrow Hospital. In fact, he himself still carries a weak right leg as a legacy of that same epidemic. A sister, Patricia, still lives in Lansing, too, and she recovered from her bout completely.

HAD ANYONE EVER TOLD THEM about the Lansing strain of polio virus and Herbert's minor niche in medical history? Of course not. Even Doctor Shaw, who still practices in Lansing, was unaware that his tolerance to the scientific fervor of a new intern had sparked an improbable trail from Lansing to Washington, from Peet to Armstrong, to Weller and Enders, to Salk and Sabin; to a time now when interns don't know that once doctors couldn't take vacations in August, that there were three strains of polio virus or that poliomyelitis was once met with numbness and resignation.

Interestingly enough, the Frank family moved to Lansing from Grand Rapids only three weeks before Herbert's death. The incubation period of polio being what it is, the virus was almost certainly acquired there and transplanted to its new city. In all fairness, it should more properly have been called the "Grand Rapids" strain or, perhaps, the Herbert Frank strain, the Rood-Shaw strain, or the Peet-Armstrong strain. Maybe the impartial and anonymous "Type II strain" is the best designation after all, though, because the virus is worldwide in distribution, or it was at one time. For at least five years there hasn't been a sign of its presence in Lansing.

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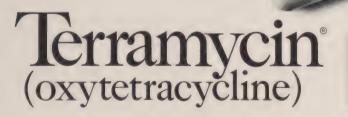
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Scientific Articles Printed to Date

Each month *Michigan Medicine* prints selected outstanding scientific articles. To date, the following papers (with month, page number and author following) have been published:

JANUARY

- Page 31, "Lower Lung Field Tuberculosis," by Ma. Zenaida Fernandez, M.D., Zamboanga City, The Philippines, and Edward G. Nedwicki, M.D., Allen Park.
- Page 36, "Use of Cholesterol Kits," by Kenneth R. Wilcox, M.D., (Reprint from New England Journal of Medicine, Vol. 279, No. 18).
- Page 37, "Mammography and Xeroradiography," by John N. Wolfe, M.D., Detroit.
- Page 39, "Early Management of Facial Nerve Trauma," by Roger Boles, M.D., Ann Arbor.
- Page 45, "Treatment of Hypercalcemia," by Joseph J. Weiss, M.D., and Jose Yanez, M.D., both of Eloise.
- Page 49, "More Drugs Mean More Problems in Managing Diabetes Mellitus," by John B. Bryan, M.D., F.A.C.P., Royal Oak.

FEBRUARY

- Page 119, "The Future of Private Practice: Salvation at the Grassroots;" by Lewis A. Miller, Stamford, Conn.
- Page 131, "Mouse Toxicity of Triple Vaccine (DTP) Mixed with Poliomyelitis Vaccine," R. Y. Gottshall, G. R. Anderson, E. A. Nelson and K. R. Wilcox, M.D., all of Lansing.
- Page 135, "Massive Intra-articular Injection of Methylprednisolone without Harmful Side Effect," by J. C. Breneman, M.D., Galesburg.

MARCH

Page 209, "Myocardial Infarction During Hyperthyroidism," by Robert C. Douglass, M.D., Southfield; Myer Teitelbaum, M.D., Detroit, and Gerald J. Aben, M.D., Southfield.

- Page 213, "Trichophyton Violaceum," by James D. Stroud, M.D.; Jules Altman, M.D., and Coleman Mopper, M.D., all of Detroit.
- Page 215, "Psychiatric Referral of a Pediatric Patient," by Joan R. Chodorkoff, Ph.D., and Bernard Chodorkoff, M.D., Ph.D., both of Detroit.
- Page 217, "Development of a Program of Laryngoscopy, Therapeutic Bronchoscopy and Endobronchial Blocking Techniques: A Progress Report," by Martin L. Norton, M.D., F.A.C.C.P., Detroit.
- Page 220, "Accidental Poisoning, Where Do We Go From Here?" by George M. Lowrey, M.D.
- Page 221, "Diabetes and Pregnancy Preliminary Report," by Nancy T. Caputo, M.D., and Agna N. Pineda, M.D., both of Detroit.
- Page 223, "The Electrophoresis of Lipoproteins," by John G. Batsakis, M.D., and Martha M. Thiessen, M.S. (ASCP), both of Ann Arbor.

APRIL

- Page 341, "Suprapubic Cystostomy In Gynecologic Surgery," by Morton R. Lazar, M.D., F.A.C.S., F.A.C.O.G., and Eugene A. Snider, M.D., both of Detroit.
- Page 345, "Rhabdomyosarcoma: Report of 20 Cases," by Lawrence S. Bizer, M.D., Detroit.
- Page 349, "Psychiatric Referrals In A General Hospital," by Wiecher H. Van Houten, M.D., Ann Arbor.
- Page 353, "The Sinai Hospital Low Vision Clinic," by Morris J. Mintz, M.D., Ernest M. Gaynes, O.D., and Arnold H. Gordon, O.D., all of Detroit.
- Page 357, "The Physician and Differential Diagnosis of Communicative Disorders in Children,"

by Gerald S. Light, M.D., and William Wolski, Ph.D., both of Flint.

MAY

The issue featured special Michigan Week articles by leaders in health care in Michigan.

JUNE

Page 571, "An Emergency Air-Ground System for Newborn Infants with Emergency Distress Syndrome," by L. J. Arp, Ph.D., R. E. Dillon, Mary Tom Long, M.D., and C. L. Boatwright, M.D., all of Blacksburg, Va.

Page 575, "Experience with Thyroid Malignancy in a Private Referral Laboratory," by Joel I. Hamburger, M.D., Southfield.

Page 581, "A Diabetic Has A Stroke," by Richard D. Hohl, M.D., Detroit.

Page 581, "Night Dose May Control Brittle Diabetic," by Jack A. Litwin, M.D., Detroit.

Write for literature and samples:

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Page 685, "Anterior Mediastinotomy As A Means of Diagnosing Bronchogenic Carcinoma," by S. Amjad Hussain, M.D., B.S., David Glow, M.D., and J. C. Rosenberg, M.D., all of Toledo, Ohio.

Page 687, "Christmas Disease With Multiple Familial Occurrence," by Frank D. Johnson, M.D., Robert K. Rank, M.D., and Robert Straley, M.T., all of Mt. Pleasant.

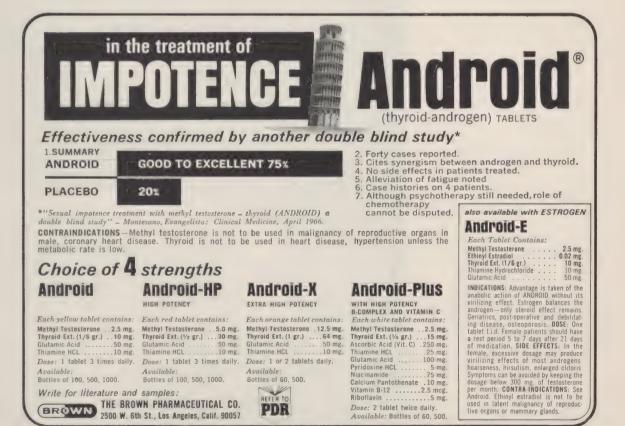
Page 691, "Phenylketonuria in Newborns," by K. Stanley Read, Ph.D., Lansing, Richard J. Allen, M.D., Ann Arbor, and Theresa B. Haddy, M.D., Lansing.

AUGUST

Page 795, "The Michigan Rheumatic Fever Study: Clinical Characteristics of Children Attending MDPH-Sponsored Cardiac Field Clinics," by Walter G. Parker, M.D., M.P.H., Ann Arbor.

Page 803, "Cardiac Views: Treatment of Shock Following Myocardial Infarction," by Jay N. Cohn, M.D., Washington, D.C.

Page 807, "Rhino-Orbital-Cerebral Phycomycosis," by C. Kohler Champion, M.D., U.S. Army, Germany, and Tom M. Johnson, M.D., East Lansing.



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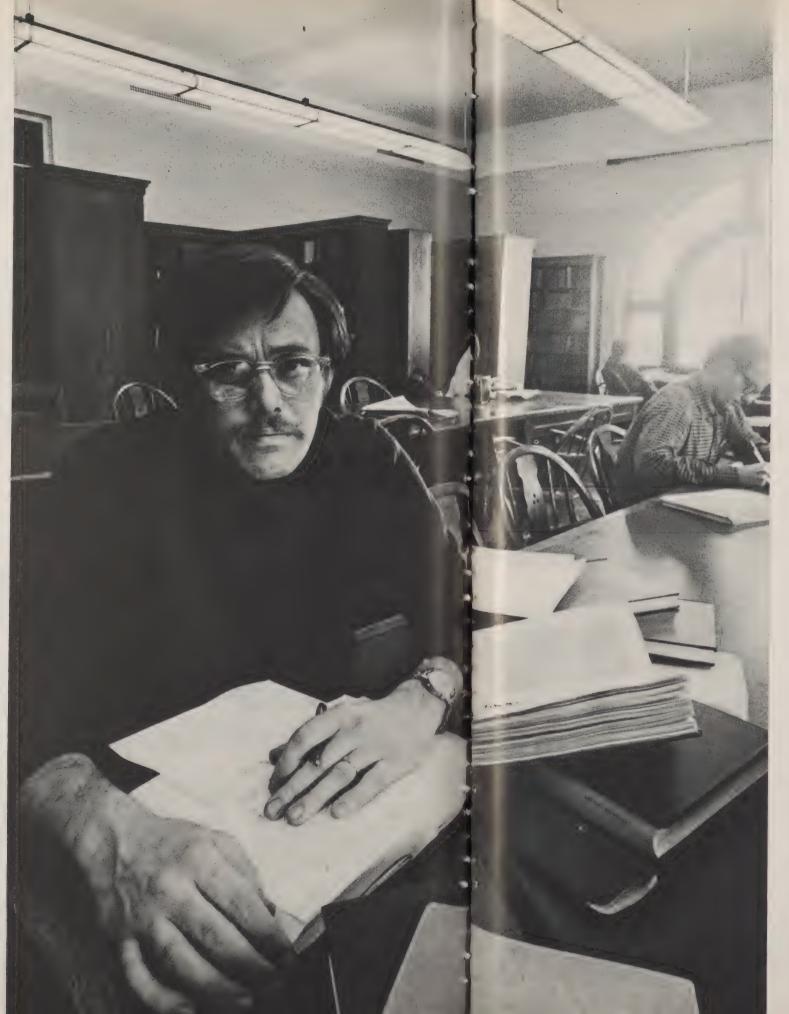
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M. A. (class of '66)...Ph.D. (thesis, in progress)...letters that represent a young lifetime of work...a formal education nearing completion. But there are still long, arduous examinations to pass, a doctoral thesis to finish...a period in which stress is often converted into the gastrointestinal symptoms of psychic tension. For this kind of patient—with no demonstrable pathology—consider the usefulness of Valium (diazepam).

Valium can help relieve psychic tension and resultant somatic symptoms, within the first day for some patients. Valium is also useful in psychic tension with associated depressive symptoms. And Valium can help relieve psychic tension-induced insomnia with an h.s. dose added to the t.i.d. schedule.

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months of age. Acute narrow angle glaucoma.

Warnings:Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Statewide Organization Planned For Michigan's Many Health Career Clubs

BY JOHN HYDE, COORDINATOR HEALTH MANPOWER RECRUITMENT MICHIGAN HEALTH COUNCIL

With the pressing need for health manpower becoming more apparent, it is fortunate that there is much interest among the young people of Michigan in health careers. This is shown in the increasing number of health careers clubs, Boy Scout medical explorer posts and other healthrelated activities being conducted throughout the State.

The Michigan Health Council is interested in promoting this type of activity as an important part of its expanded Health Manpower Recruitment Program. The MHC is ready to offer assistance to groups in organizing and in program planning. Also, activities are being planned on a state-wide basis in an effort to acquaint students with the activities of other groups similar to their own. The promotion of health careers clubs is meant to include all of the 200-plus health occupations and training programs.

FALL PLANS

In June a group of health careers club members, and advisors met with the Michigan Health Council staff to explore and make plans for the coming school year. MHC Executive Director John A. Doherty explained that interest in a state organization has been shown for some time and that the National Health Council presently is exploring the possibility of a national association.

President Nancy Hamilton and advisor Mrs. Louise Burgess of Ann Arbor represented the Pioneer High School club; Mrs. Marlene Rattray, the St. Clair Shores club; Mrs. Elaine McLellan and Mrs. Opal Fraser, the Health Careers Council of Calhoun County, Inc., Tom McLellan, President of the newly formed club at Lakeview High School, Battle Creek, and Mrs. Marion Anderson of Flint Northwestern all were in attendance.

This advisory committee offered suggestions for state-wide activities, organizing the state association with student officers, improving program planning for local clubs and a state-wide conference for the Health Careers Clubs of Michigan.

The MHC is in the process of identifying the existing clubs and instigating the formation of

new groups where interest has been shown. It is hoped that each group will become charter members of the Health Careers Clubs of Michigan.

HEALTH WEEK PRIORITY

This fall the 1969 Community Health Week will give high priority to featuring health careers because of the pressing need for health manpower. The MHC is promoting appropriate activities in which clubs might engage to promote health careers in their respective communities.

One state-wide project, in the planning stage, will be a Health Careers Poster Contest. Students from the 6th through the 12th grade will be eligible. Each health careers club will be asked to conduct a contest in the school, and state winners will participate in the national contest. The American Hospital Association will conduct the National contest in connection with National Hospital Week. The state winners will be announced and awards given by Governor Milliken on October 20 during Community Health Week.

Michigan has several hundred health careers clubs presently in operation. Some of the more active are Mrs. Milton Palmer's group at Martin Luther King High School in Detroit and Calhoun County's seven, including two new clubs organized last year at Lakeview and Pennfield High Schools in Battle Creek.

Still more groups studying health careers in the state are Future Nurses Clubs at Portage High School, Hillsdale, Milan, Greenville, Plymouth, Constantine, Ladywood in Livonia, Fruitport, and Summerfield High School in Petersburg. Chelsea, Rudyard and Fowlerville have Health Careers Clubs. Ann Arbor Pioneer High is reorganizing their club to include all of the health occupations. This fall Glen Lake Community High School in Maple City, Albion High School and Our Lady Star of the Sea High School in Grosse Pointe Woods will be organizing. Northwestern High School organized this spring with 150 interested students from whom 40 were selected to participate in the unique Summer Exploratory Experience Program involving the school and four area hospitals. Mrs. Kahl, a counselor and sponsor for

the Rudyard group, states that they sponsor a scholarship annually for a deserving senior entering a health career vocation.

To add to the show, girls are being accepted in the Boy Scouts Medical Explorer Posts. There are over 25 groups in Michigan including many in the Detroit area, Greenville, Albion, Pontiac, Lansing, Marquette, Midland, St. Joseph, Jackson, Dundee, and Ypsilanti. The Explorer program alone involves over 500 potential prospects for health manpower.

With all of the fine programs in operation, many of the health career possibilities are being examined by many students who are searching for an occupation which they can do well and enjoy.

New Worlds Opened to Detroit Youngsters Following Unique Health Careers Program

Careers in health look highly intriguing and possible to 40 Detroit Northwestern High School students following the six weeks they spent "interning" in four Detroit hospitals this summer.

And the unique six-week Summer Exploratory Experience (SEE) Program in Health Occupations has proved so successful with the Detroit youngsters that its sponsors announce it will be continued in the fall.

Joshua Geller, Ph.D., coordinator of the program and assistant principal at Northwestern High School, Detroit, from which the 40 students were drawn, announced in addition that all the participating students have been offered part-time positions starting in the fall at the hospitals they visited this summer.

The youngsters, most of them members of the Northwestern Health Club, spent three hours a

See related art, page 932

day in the classroom and three hours rotating their time to include all sections of the hospital set-up. The students were paid five dollars a day for participating and received five high school credit hours.

The three-hour classroom period the students attended each day during the summer will be continued at 7:15 a.m. each school day during the fall in a condensed one-hour version. Teachers and administration at the school are so impressed with the program they have volunteered to come in at the early hour on their own time.

Miss Jacqueline Tilles, instructor for the summer program, who will be on the faculty of Wayne State University beginning in September, will also volunteer her services for the 7:15 a.m. class.

"I'm learning things I never knew before," said an enthusiastic Randy Hands, a junior at Northwestern, when he was interviewed one day during the summer program. "I'm seeing things I never knew they had in hospitals, like libraries and nutritionists.

Raymond Boatwright, senior, decided after observing doctors and nurses at work, that he'd like

to be a physical therapist instead of a basketball player.

Dorothy Hawkins, junior, was excited about the program because "you have so many different experiences and it helps you decide what you want to be.

"The best part of working in the hospital is the interesting people you meet," Dorothy said. "The head nurse, for example, sat down and told us all about nursing and answered questions. And one day the hospital administrator talked to us. He told us we could be anything we wanted if we just tried."

The Michigan Health Council, sponsors of the SEE program, are trying now to gain continued cooperation from private industry, such as the Chrysler Corporation Fund, which financed the summer program and carries on a continuing career-help program with Northwestern High students.

Lionel F. Swan, M.D., Detroit, past-president of the Detroit and National Medical Associations, lauded the efforts of all in the program at an Aug. 7 banquet closing the summer session.

James D. Fryfogle, M.D., president of the Wayne County Medical Society, offered his organization's help in making the program a city-wide project.

The Health Council, according to John A. Doherty, executive director, hopes to involve at least 400 Detroit students in exploratory hospital programs by 1970.

Arthur Templeton, Ph.D., director of the World of Work cooperative program of the Detroit Public Schools, commented recently that "this entire program is doing much more for the students than most programs that cost many, many times more."

Hospitals involved have also reported that the "health interns" have been most helpful with the patients, giving assistance wherever possible to the hospital staff. "We like having the teen-agers with us in our hospitals," they say.

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

OFTEN... HER LOWER G. I. TRACT

Psycho-abdominal Distress: Frequently Female

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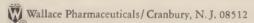
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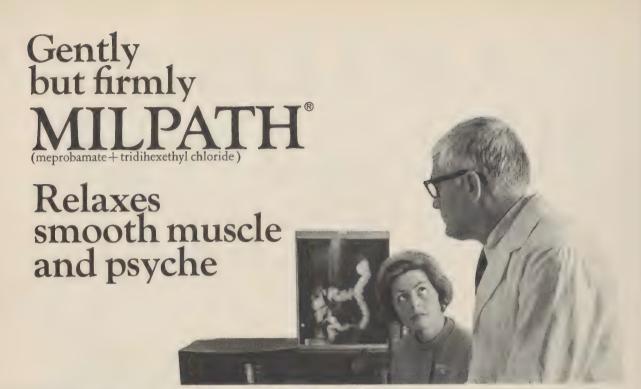
- 'Milpath'-400 (meprobamate 400 mg. + tridihexethyl chloride 25 ing.) Usual adult dose: 1 tablet t.i.d. and 2 at bedtime.
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Indications

Useful in organic and functional disorders with hypersecretion and hypermotility of G.I. tract, especially when accompanied by anxiety, neurosis, or tension states. Should be used as an adjunct to all other therapeutic measures.

Contraindications

Tridihexethyl chloride: Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus: organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention.

Meprobamate: Previous allergic or idiosyncratic reactions to meprobamate.

Precautions

Tridihexethyl chloride: Use cautiously in elderly males (pos-

sible prostatic hypertrophy).

Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

Side Effects

The following side effects of components may occur with 'Milpath'.

Tridihexethyl chloride: Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral

doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness.

Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.

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Before prescribing, consult package circular.

References

1. Harrison, T. R., et al.: Principles of Internal Medicine, Fifth Edition, New York, The Blakiston Division, McGraw-Hill Book Company, 1966, p. 1019. 2. Bockus, H. L.: Gastroenterology, Second Edition, Philadelphia & London, W. B. Saunders Company, 1964, Vol. II, p. 729 et seq. (1928A01J)

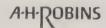


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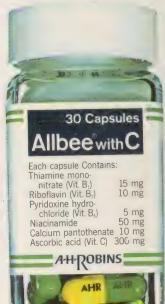
Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.





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Detroit Teenagers Explore Health Careers

WHERE THE ACTION IS — In a history-making program, Northwestern High School students are getting a firsthand view of an operation at Metropolitan Hospital, Detroit. Observing preparation of the patient are Maryanne Robinson, Josephine Smith and Raymond Boatwright, from left. (Detroit News photos).



HELPING HAND — Obie Goree, Northwestern junior, prepares heat therapy equipment in Physical Medicine at Metropolitan Hospital.



EASY DOES IT - Northwestern High School's Florence Harper gives oxygen under the watchful eye of Henry Kelly, chief inhalation therapist.

FATHER THOMAS KAUFFMAN, center, supervises a group of his Silesian High School students at work on summer science research sponsored through scholarships from the Michigan Cancer Foundation. For the sixth summer, MCF selected 49 Detroit-area high school students for eight-week research projects chosen by the students who work in their own school labs.







Michigan Cancer Foundation **Sponsors** High School Research

INSPECTION OF EQUIPMENT is important to Thomas Bumol of Osborne High, Detroit, who spent the summer studying insecticides and their relation to leukemia.

BUSILY GROWING CULTURES of micro-organisms in his Osborne High School, Detroit, laboratory, is Ken Mueller, one of the 49 students on summer, '69 MCF scholarships.

TEST FOR GLAUCOMA is administered by Mrs. Ruby Taylor, R.N., under the watchful eye of John A. Cowan, M.D., medical director of the State Employees Group Insurance Health Maintenance Unit which under Doctor Cowans' direction began in July a multiphasic screening test program in Lansing, Kalamazoo and Detroit for state employees.



SIXTEEN BLOOD CHEMISTRY tests are made to detect disease in state employees from blood samples taken in the new multiphasic screening program. Each test is administered by specially trained nurses and technicians, under the direction of a physician, as private examinations are not feasible in this time of physician shortage. It is anticipated that more clinics for state employees' testing will be opened soon in Kalamazoo and Detroit. A full report on the screen program by Doctor Cowan appeared in the August issue of Michigan Medicine.



A DISTINGUISHED SERVICE award for a career dedicated to the control and eradication of tuberculosis was presented to Winona Barrows, M.D., by the Southwestern Region of the Michigan TB and Respiratory Disease Association. Doctor Barrows, pictured here with her award, received the award as she presided over the annual meeting of the Southwestern Michigan TB Detection Project July 9 in Kalamazoo. Doctor Barrows has served as medical superintendent of the Southwestern Michigan Tuberculosis Sanatorium since 1960. The San was closed this year by the Michigan Department of Public Health with the decrease in TB patients.





A MOST EXTRAORDINARY companion to the 50 children undergoing extended inpatient treatment at the University of Michigan's Children's Psychiatric Hospital is the lovable, intelligent Skeezer. Part Labrador, part German Shepherd and part mystery, Skeezer is marking her third anniversary as fulltime "resident canine" at the hospital. She is photographed here with Alice Williams, R.N. Skeezer's delivery of nine puppies at the hospital and an injury to her paw and its subsequent treatment have provided excellent learning opportunities for the children. She greets incoming patients at the hospital door, serves as an outlet for affection for the children, and, says Stuart M. Finch, M.D., chief of the children's psychiatric service, "In many instances the first sign of progress from our youngsters has been noted in their relationship with Skeezer."

THE EARLY HISTORY of Detroit's Harper Hospital is brought to mind by this photograph, depicting the first building, an administration building flanked on each side by four barracks-type wards. Harper was first built in 1864 on the site of the present hospital and was reserved for casualties of the Civil War. Food and volunteer help was donated by the good ladies of the Presbyterian Church. Entertainment and socials were offered for ambulatory patients. Harper was soon filled to its capacity. It became so crowded that amputations were even performed on the admitting desk.





Kresge Foundation Endows Michigan Projects

The Kresge Foundation of Detroit recently issued its 1968 Annual Report describing many of its recent projects, some of them Michigan-based, as pictured here. The Foundation, which was founded in 1924, has made grants of over \$9 million to 679 recipients in 45 states, the District of Columbia, Puerto Rico and 11 foreign countries.

THE KRESGE FOUNDATION in 1968 authorized \$600,000 toward construction of new quarters for the Kresge Eye Institute of Wayne State University, to be built within the new Harper-Webber Hospital in the Detroit Medical Center. It is the intention of the Kresge trustees to grant \$208,-000 each year from 1969-72 to the eye institute. All such grants, with the \$400,000 approved in 1965, will provide a total for the project of \$1,-232,000 from the Kresge Foundation.



The Kresge Foundation of Detroit authorized two grants to Young Men's Christian Associations in 1968. One was the Macomb YMCA which received a grant toward a new \$1 million building which houses this pool.



PLEASANT AND SPACIOUS, the Baker-Kendrick Room of the M. J. Clark Memorial Home in Grand Rapids, is part of a rebuilt west wing of the building made possible through a \$75,000 grant by the Kresge Foundation. The Methodist home for the aged has been in existence 62 years and now serves 341 persons. Included in the west wing, which was demolished and rebuilt in 1968, are living quarters and offices.



BOB WATSON THOUGHT safety belts were too confining; what's your excuse? That copy and the graphic photograph at right are featured in the latest magazine campaign being sponsored by the National Safety Council-Advertising Council campaign to get people to use their seat belts while driving. The MSMS House of Delegates and committees often have urged every physician to set a good example and buckle up for safety.

"BEFORE AND AFTER" photographs of a scale model illustrate the principle of "Encapsulated" buildings to be tested for the Michigan State University Olin Health Center addition with the support of a grant of \$437,572 from the U.S. Public Health Service.



"Magic and Medicine" Theme of Special Exhibit At MSU Museum

Beliefs about disease, its causes and cures, have been central to the culture and religion of all human groups. This is the theme of a new Michigan State University Museum exhibit, "Of Magic and Medicine."

The eight-case exhibit traces medicine from its origin in magic and myth, through quackery and misunderstanding, to its present standing at the crossroads of many sciences. The exhibit, developed by Dirk Gringhuis, curator of exhibits, features the Michigan State University's College of Human Medicine, which recognizes the importance of preventive medicine and of treating the whole man.

The point is made that the medical quack, with his "magic" remedies, still exists, due to primitive thinking of civilized people and the inability of modern science to promise a cure for every illness.



PLANTS RENOWNED IN folk lore are part of exhibit depicting progress of medicine from its early origins.

MSU MUSEUM CURATOR Dirk Gringhuis, left, with MSU College of Human Medicine students Harold G. Scholin, Jackson, center, and Rodney K. Justin, Milford, discuss artifacts in new "Of Magic and Medicine" exhibit.





unwelcome bedfellow for any patient-including those with arthritis, diabetes or PVD

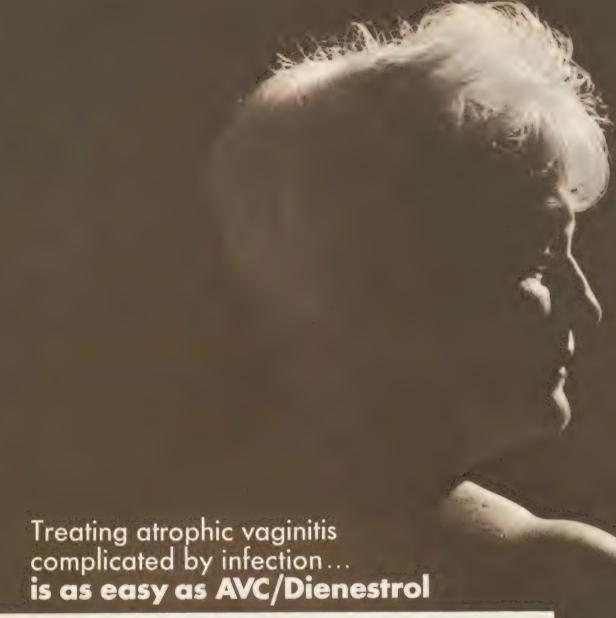
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information - Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. Indications: For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. Contraindications: QUINAMM is contraindicated in pregnancy because of its quinine content. Precautions/Adverse Reactions: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. Dosage: One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. Supplied: Bottles of 100 and 500 tablets.



THE NATIONAL DRUG COMPANY DIVISION OF RICHARDSON-MERRELL INC PHILADELPHIA, PENNSYLVANIA 19144

Specific therapy for night leg cramps



Dienestrol helps restore estrogen-deficient vaginal mucosa.

It is the particular ingredient in AVC/Dienestrol that improves cell maturation counts^{1,2}

— helps stimulate the restoration of normal vaginal epithelium to resist infection.

Two recent studies reconfirm AVC/Dienestrol efficacy. 1,2 AVC/Dienestrol is proven effective against monilial, trichomonal, nonspecific bacterial vaginitis, and mixed infections. 1,2 AVC/Dienestrol combats infection, helps restore tissue resistance to reinfection.

So even in complex cases, the treatment can remain the same. Comprehensive. Effective. Easy as AVC/D.

Contraindications: Known sensitivity to sulfonamides; diagnosis or familial history of carcinoma of the genital tract or breasts; precarcinomatous lesions of the vagina or vulva; palpable uterine fibromyoma; mammary fibroadenoma; depressed liver function.

liver function.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of obsorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity or sensitivity are reasons to discontinue treatment. The use of AVC/Dienestrol does not preclude the necessity for careful diagnostic measures to eliminate the possibility of neoplasia of the vulva or vagina, Manifestations of excessive estrogenic stimulation through dienestrol absorp-tion may occur. These include uterine bleeding, breast lender-ness, exacerbation of menstrual irregularity and provocation of serious bleeding in women sterilized because of endometriosis.

Endometrial withdrawal bleeding may occur if use is suddenly

discontinued.

Dosage: One applicatorful or one suppository intravaginally

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: 'AVC/Dienestrol Cream'—Four ounce tube with applicator. 'AVC' and 'AVC/Dienestrol Suppositories'—Box of 12 with applicator.

References: (1) Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.



THE NATIONAL DRUG COMPANY DIVISION OF RICHARDSON-MERRELL IN PHILADELPHIA, PENNSYLVANIA 19144

Cream (dienestrol .01%, sulfanilamide 15.0%, aminacrine hydrochloride 0.2%, allantoin 2.0%) Suppositories (dienestrol 0.70 mg., sulfanilamide 1.05 Gm., aminacrine hydrochloride 0.014 Gm., allantoin 0.14 Gm.)



COUNTY SOCIETIES

UP Society Sets Next Annual Meet

Members of the Upper Peninsula Medical Society have already set the dates of June 17-19 and Sault Ste. Marie as the site for their 1970 annual meeting. Some committee appointments have already been made and the work has started on the convention program. W. F. Mertaugh, M.D., new president, will be in charge.

Genesee Doctors Boost Local Projects

Two community projects have been boosted recently by the Genesee County Medical Society. The GCMS was one of 20 Flint-area groups contributing a total of \$27,000 to a \$35,000 study to be made of local social services. The Genesee members also sponsor a medical Explorer Post of the Boy Scouts, which is one of several in the state which have recently gone co-ed. The Scouts meet monthly at a local hospital and have learned about cardiac surgery, cardiac catherization, hemodialysis, X-ray physics, laboratory procedures and the daily processes of a busy general practice.

Oakland Society Golf Winners

Winners of the recent Oakland County Medical Society Golf Outing include F. Michael Sheridan, M.D., low gross; Adolph Bruni, M.D., low net; Ken VandenBerg, M.D., longest drive and Charles I. Patrick, M.D., putting champ.

Kent and Muskegon Meetings Interesting

Recent Muskegon and Kent County Society meetings have carried provocative and interesting subjects. The Muskegon Society was invited to a joint meeting by local osteopaths which prompted Bulletin editor Austin Aardema, M.D., to comment "It's high time we all got together in more ways than this." Another Muskegon meeting included a panel discussion on Industrial Medicine organized by the Muskegon Manufacturers' Association, while nearby Kent society members heard Louisville, Ky., university professor and dean Henry M. Johnson, Ph.D., on the topic, "Maximum Matrimonial Mileage with Minimum Misery."

MSU Physicians Address Berrien MDs

"Modern Blood Transfusion Therapy; Shock" was the topic of a recent meeting of the Berrien County Medical Society which featured speakers from the Michigan State University College of Human Medicine.

Saginaw MDs Sponsor Arthritis Forum

The Saginaw County Medical Society, in cooperation with the Saginaw United Fund and Michigan Arthritis Association, sponsored a public forum on arthritis early this summer at Saginaw Arthur Hill High School. Panelists included J. W. Signerl, M.D., Detroit, head of the rheumatology section of Henry Ford Hospital, and Jack Martin, M.D., orthopedic surgeon, and Bert Bullington, M.D., internists, both of Saginaw.

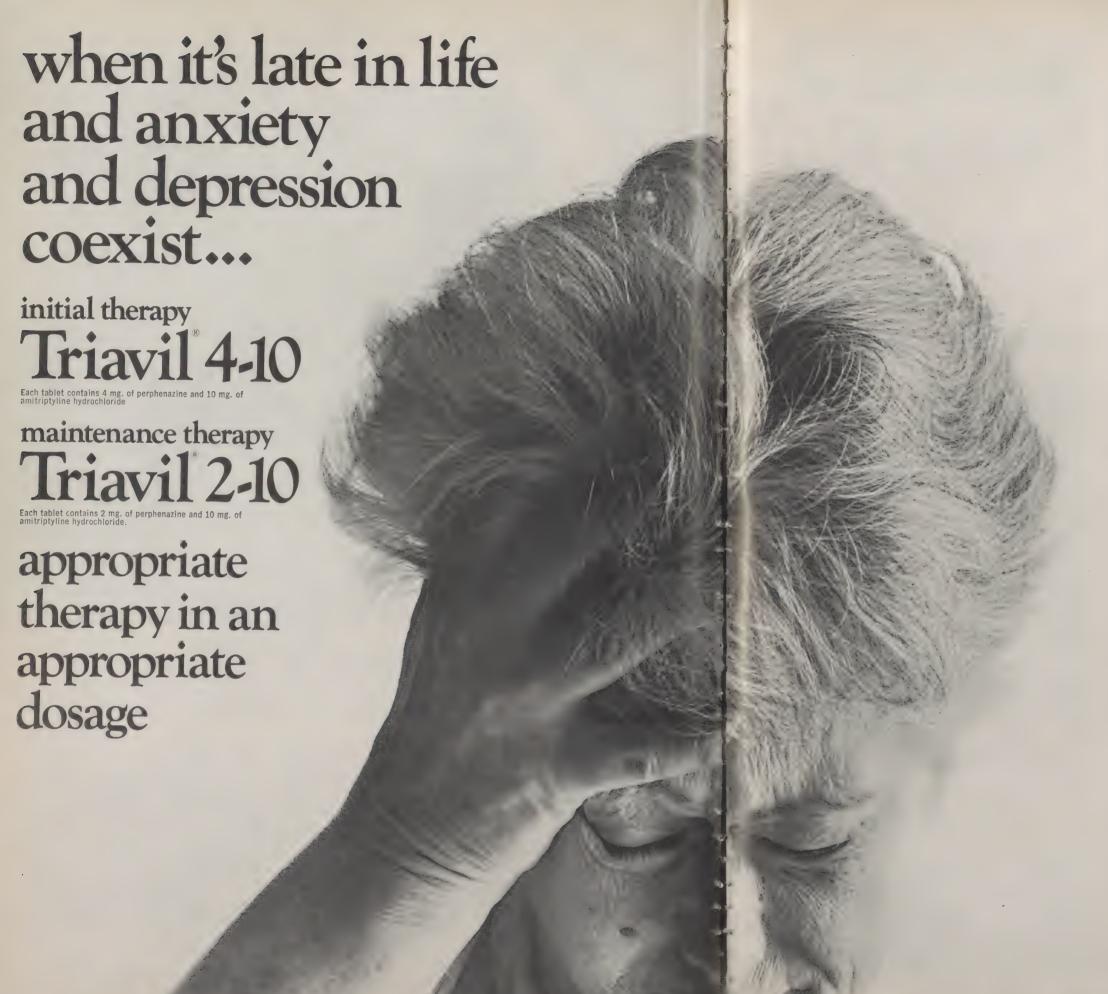
Ingham Society Determines Need For 70 Physicians

At least 70 more physicians, representing 13 different specialties, are needed in the Greater Lansing area, according to a survey conducted recently of Ingham County Medical Society members.

The survey was organized by the Public Health Committee of the county medical society, which asked members to fill out postcards estimating the number of additional doctors needed in their own specialties, if any, and ranking in order all of the specialties each doctor believed were needed most in the county.

A total of 121 physicians responded.

The greatest need in the county, they said, was for general practitioners, with 20 more the average number desired. Following that were internists, ENT, pediatrics, anesthesiology, neurology, ophthalmology, urology, psychiatry, orthopaedic surgery, proctology, radiology, obstetrics-gynecology, neurosurgery and plastic surgery.



During the years of declining strength and increasing infirmity, many patients are more sersitive to both the desired response and the unwanted effects of some drugs. That's when low-dosage therapy is needed. And that's when TRIAVIL 4-10, as initial therapy, and TRIAVIL 2-10, for maintenance, can prove particularly

Starting with Triavil 4-10 should help minimize possible dose-related side effects in the geriatric patient with coexisting anxiety and depression. And, subsequently, TRIAVIL 2-10 can increase flexibility in adjusting maintenance

Activities made hazardous by diminished alertness should be avoided. You will want to inform your patients that the effects of alcohol may be potentiated. Because of the potentiation of other drug effects possible with MAO inhibitors, such agents should not be given concomitantly with TRIAVIL. However, therapy with TRIAVIL can be initiated cautiously two weeks or more after withdrawal of the MAOI drugs. And, until significant remission is observed, close supervision of any seriously depressed patient is, of course, essential to guard against possible suicide. The drug is contraindicated in glaucoma, in patients expected to experience problems of urinary retention, in drug-induced CNS depression, and in bone marrow depression. TRIAVIL 4-10 & 2-10—tranquilizer-antidepressant therapy especially appropriate for the elderly patient so often intolerant to medication in high dosages.

TRANQUILIZER-ANTIDEPRESSANT depression

® for moderate to severe anxiety



TRIAVIL TRANQUILIZER-ANTIDEPRESSANT

TRIAVIL 4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL 2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL 4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL 2-10: For use in adjusting maintenance dosage. Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

for moderate to severe anxiety with coexisting depression

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory reponse.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated. PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone. Perphenazine: Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/

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Division of Merck & Co. INC. West Point. Pa 19486
Where today's theory is tomorrow's therapy

or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe, acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis): other allergic reactions (asthma, laryngeal edema, angioneuroticedema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol). atropine, heat, and phosphorous insecticides. Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Before prescribing or administering, read product circular with package or available on request.

Michigan Mediscene

- August 18 American College of Emergency Physicians, MSMS Headquarters, East Lansing, 5:00 p.m.
- Sept. 14 Michigan Academy of General Practice, Board of Directors, MSMS Headquarters, East Lansing, 2:00 p.m.
- Sept. 15-16 29th Annual AMA Congress of Occupational Health, Stouffer Riverside Inn, St.
- Sept. 18 Michigan Chapter, American College of Emergency Physicians, MSMS Headquarters, East Lansing, 7:00 p.m.
- Sept. 19-21 Joint Meeting of Michigan Chapter, American College of Physicians and Michigan Society of Internal Medicine, Grand Hotel, Mackinac Island.
- Sept. 22 American College of Emergency Physicians, MSMS Headquarters, East Lansing, 5:00 p.m.
- Sept. 28-Oct. 2 MICHIGAN STATE MEDICAL SOCIETY 104th ANNUAL SESSION, Sheraton-Cadillac Hotel, Detroit.
- Sept. 28 MSMS COUNCIL, Sheraton-Cadillac Hotel, Detroit, 10:00 a.m.
- Sept. 30-Oct. 2 MSMS WOMAN'S AUXILIARY ANNUAL CONVENTION, Pontchartrain Hotel, Detroit.
- Oct. 1 MSMS COUNCIL, Sheraton-Cadillac Hotel, 8:00 a.m.
- Oct. 8-11 12th National Conference on Physicians and Schools, Pick-Congress Hotel, Chi-
- Oct. 12 AMA Midwestern Regional Conference on "Voluntary Health Agencies and American Medicine," Stouffer Hotel, Indianapolis.
- Oct. 19-25 7th Annual Community Health Week.
- Oct. 23 2nd ANNUAL SEX EDUCATION WORKSHOP, MSMS Headquarters, East Lansing, All Day.
- Oct. 27 American College of Emergency Physicians, MSMS Headquarters, East Lansing, 5:00 p.m.
- Oct. 29 4th Diabetes Day, Genesee County Medical Society, Flint, All Day.
- Nov. 5 MSMS COUNCIL, MSMS Headquarters, East Lansing, 9:30 a.m.
- Nov. 9 MICHIGAN STATE MEDICAL AS-SISTANTS SOCIETY, MSMS Headquarters, East Lansing, 11:00 a.m.
- Nov. 19-21 American College of Emergency Physicians Scientific Assembly, Denver, Colorado.
- Nov. 20 Lansing Dietetic Association, MSMS Headquarters, East Lansing, 7:00 p.m.

County Leaders Reminded Of Blue Shield Committees Review Services

Ross V. Taylor, M.D., Chairman of the MSMS Council, has issued a memo to all presidents and secretaries of county medical societies, reminding them of the continuing utilization review services of the Regional Medical Advisory Committee of Blue Shield.

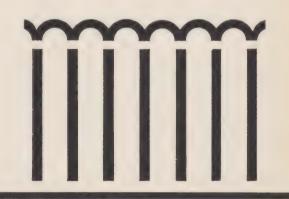
The committee, as formed by a resolution adopted by the MSMS House of Delegates in 1968, was to exist for utilization review and availability as an appeal mechanization.

But, notes Doctor Taylor, "In some areas there has been more emphasis on the appeal mechanisms than on the utilization review.'

During recent meetings The Council has discussed the matter of interpretation of claims and adjudication of fees with the Michigan Medical Service in some depth, reports Doctor Taylor. The Council holds that, in situations where any carrier questions a physician's charges, it should first contact the involved physician and review the matter with him; then, if necessary, turn to the local county medical society; lastly, if Michigan Medical Service is involved, the matter should be referred to the Regional Medical Advisory Committee of Blue Shield.

The Council has expressed its firm opinion that all steps should be taken to insure that questions of charges be resolved between carriers and physicians before correspondence regarding them is initiated with subscribers, said Doctor Taylor,

"The problems of utilization review are very important," he said in his memorandum. "It is emphasized that this is a major function of these medical advisory committees. Please be aware of their continuing review."



OUR STATE SOCIETY



Meeting of June 4, 1969

Extract of MSMS Council Minutes

MVF — The Council's monthly report from Michigan Medical Service covered the subject of MVF over - the - screen communication, drug program implementation and regional medical advisory committees. Also distributed to The Council was a Report of Continuing Experience on Medicaid and Michigan Blue Shield January 1-December 31, 1968.

MEDICAID — The Council received a detailed report from Chairman Taylor who attended a meeting of the HEW Ad Hoc Task Force to consider proposals to curb rising costs of Medicaid. This meeting was held in Washington, D.C., on May 24. Copies of this report had been sent to various officers and interested persons in Michigan and throughout the nation since Doctor Taylor was serving as the representative of the medical societies.

MEETINGS — The Council also received reports from representatives it had sent to meetings as follows: Report of Second Meeting of the American Medical Association and the Joint Commission on Accreditation of Hospitals discussing "provisional draft of standards for hospital accreditation," Report on the AMA 22nd National Conference on Rural Health, The Third National Conference on Socio-Economics of Health Care, and the AMA-AMPAC Public Affairs Seminar, held in Washington, D.C.

EXTENDED CARE — A request was received from the Michigan Hospital Service for MSMS support in attempting to change the requirement that patients in ex-

tended care facilities must be seen by a physician a minimum of every two weeks under the auto contract, and a minimum of 30 days under Medicare. This matter was referred to the MSMS Hospital Relations Committee for review and report.

HEALTH PLANNING — The results of the survey of component medical societies regarding local activitiy in comprehensive health planning were reported to The Council and copies were made available.

MEDICAL EDUCATION — The status of the campaign on medical education was reviewed in detail and specific authorization was given for the insertion of newspaper ads to aid the public's understanding regarding the possibility of an osteopathic school being constructed and located in a manner contrary to existing MSMS policy.

PROPERTY — The Council noted that its long-time efforts to purchase the property adjoining the MSMS grounds had been fruitful and this small parcel of land had been purchased at a very reasonable cost. Since the land rests between the church property and the MSMS property it was very important that undesirable owners did not obtain the property, thus jeopardizing the value of the MSMS grounds.

CONFERENCES — Various reports on the success of the Arthritis Public Forum in Detroit, the MSMS Conference on Medical Aspects of Organized Athletics, the MSMS Conference on Medical Reporting, the Michigan Health

Congress, and MSMS quackery exhibit were reviewed.

FINANCE — The monthly financial reports were approved by the Finance Committee and The Council. The Treasurer gave a progress report on an insurance benefits study that he is investigating with MSMS Insurance Counsel.

SAMA — A request from the University of Michigan SAMA Chapter for a small grant to finance extended programs in connection with the regional SAMA meeting to be held in Ann Arbor was approved by The Council.

THE BLUES — The Council also instructed the Committee on Professional Insurance Plans to investigate the recent Blue Cross-Blue Shield health insurance rate increases and to review the experience of the MSMS group of means of a meeting, if necessary, with representatives of Blue Cross-Blue Shield.

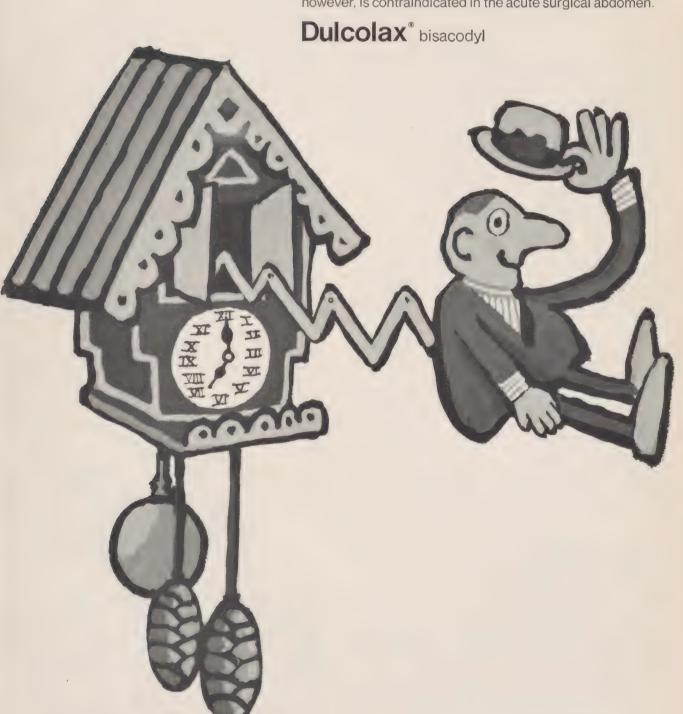
COMMITTEES—The Council reviewed reports from the Liaison Committee with the Health Insurance Council, Public Relations Committee, Ad Hoc Committee to Study Health Problems of the Disadvantaged in the cities, Committee on Value Study, Committee on Nursing, Committee on Rural Medical Service, Committee on Alcohol and Drug Dependence, Committee on Program for the 1969 Annual Session, Committee on Eye Care, the Committee on Respiratory Diseases, Committee on Medical Aspects of Organized Athletics, and Committee on Cancer.

Dulcolax ... so predictable you can almost set patients by it.

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.



MAILBAG

Michigan Medicine invites letters of 300 words or less for publication. Communications should be addressed to the Publication Committee, Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823. Unsigned letters will not be considered; but signed letters will be printed anonymously if the author so requests.

'MICHIGAN NOT SO FAR BEHIND'

To the Editor:

I am one of the physicians who do read the Journal. In the June issue page 571 there is an article on transportation of pulmonary distressed premature infants, taking them to Virginia. For nine years the northern half of the lower peninsula has had such a *safe* transportation service for bringing premature or critically ill infants to the Premature Intensive Care Center in Munson Medical Center, Traverse City, or for transportation to Ann Arbor, Detroit, or Grand Rapids for possible highly specialized service such as cardiac surgery. To this date we have transported 209 infants.

Michigan is not so far behind.

Sincerely,

E. F. Sladek, M.D., Director Department of Rehabilitation Medicine Munson Medical Center

Medical Student Reads The Journal Each Month

Recent correspondence to MSMS headquarters has included this note from a University of Michigan medical student, Stephan H. Berger, who wrote asking for a copy of *Horizons Unlimited*. He added:

"Although I am not yet a member of the MSMS, I read *Michigan Medicine* each month. I . . . appreciate very much your placement of copies of your magazine in our medical school office."

Procedures Explained For Billing U.S. Army For Doctor's Services

The procedures for Michigan physicians to follow in billing the U.S. Army for services rendered to military personnel are explained in a recent communication to MSMS from the Office of the Surgeon General.

According to the message,

"Payments for civilian sources for emergency professional services rendered to military personnel who are on active duty (as contrasted to retired, or inactive members of the National Guard or Reserve) is a responsibility of the surgeon of the geographical area in which the services are provided. Collection cannot be made from the Office for the Civilian Health and Medical Program for the Uniformed Services (OCHAMPUS) or from Michigan Medical Service, who are responsible only for the payment of medical care rendered to authorized dependents and retired military personnel.

"Michigan physicians treating active military personnel under such circumstances should contact the Commanding General, United States Army, ATTENTION: Surgeon, Fort Sheridan, Illinois 60037. The telephone number is 312 - 926-3275.

"When the patient is identified as an Army member, on active duty, notification should be made immediately by telephone (listed above) reporting where the individual is and the nature of treatment required. Reimbursement of telephone calls will be made with the other charges, as well as the administrative management of the patient and how to submit your bills for service."



For Your Library

Copies of "A Century of Service in Medicine," published as a Centennial highlight by MSMS, are still available for cost, \$2.00. The book, bound handsomely in blue, was written by Wm. J. Stapleton, Jr., M.D., of Detroit, the MSMS Historian. To obtain a copy, write to MSMS, 120 West Saginaw, East Lansing, and enclose a check.



Let's be specific about Campbell's Soups... and <u>reducing diets</u>



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to: Campbell Soup Company, Box 265, Camden, N. J. 08101

NOW STHETIME... TO GIVE HER TIME WITH OVULEN-21°

Each tablet contains ethynodial diacetate 1 mg., mestranol 0.1 mg.

The new mother needs time...
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband...
and for herself as well...
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

Each tablet contains ethynodial diacetate 1 mg., mestranol 0.1 mg.

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication-Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968^{1,2} estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortali	ty Rates	Hospitalization Rates (Morbidity)	
	Age 20-34	Age 35-44	Age 20-44	
Users of Oral Contraceptives Non-Users	1.5/100,000	3.9/100,000	47/100,000 5/100,000	

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contra-

ceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions-Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, if is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither con-

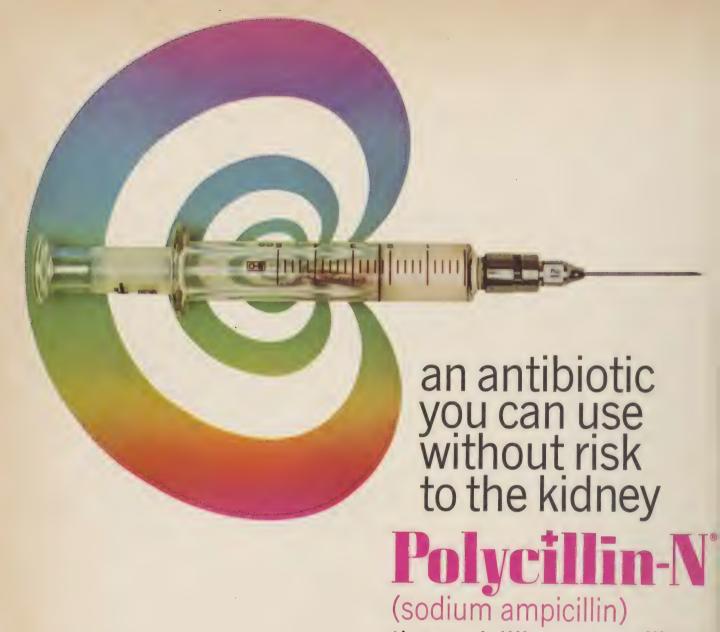
firmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T³ uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

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Indications: Infections due to susceptible strains of Gramnegative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonor-rhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has

been noted in some patients receiving the Chewable Tablets. Usual Dosage: Adults-250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children-50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./ Kg./ day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days. Supplied: Capsules-250 mg. in bottles of 24 and 100, 500 mg. in bottles of 16 and 100. For Oral Suspension-125 mg./ 5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops-100 mg./ml. in 20 ml. A.H.F.S. Category 8:12.16

BRISTOL

BRISTOL LABORATORIES Division of Bristol-Myers Company Syracuse, New York 13201 Each month specially designated pages in MICHIGAN MEDICINE will be devoted to information news briefs concerning items for your interest and knowledge about government medical programs. Those articles will briefly detail the latest pertinent changes, views and activities in order to provide information to our membership about these vital programs as they affect the medical profession.

The Committee on Governmental Medical Care Programs hopes that you direct your attention to this section and invites your comments and suggestions. Limitations on space prevent a comprehensive review of these many programs. If you are interested in a more detailed analysis please write MSMS.

Robert E. Rice, M.D., Chairman Committee on Government Medical Care Programs

COMPREHENSIVE HEALTH PLANNING

In Michigan

Michigan's CHP Commission has been advised of federal approval of grant applications for areawide comprehensive health planning funds submitted by:

United Fund and Community Services, Inc. — Grand Rapids area (second year developmental grant)

Capitol Area Comprehensive Health Planning Association — Lansing area (second year developmental grant)

Greater Detroit Area Hospital Council – (first year developmental grant)

The State Commission recently approved and recommended federal funding for the Western U.P. Health Services Council of a grant for \$54,410 to develop a U.P. Comprehensive Health Planning Federation with strong community (zone) organization.

Also recommended was continued federal funding for the newly organized South Central Health Planning Council (counties of Barry, Branch, Calhoun, Kalamazoo and St. Joseph) and certain hospitals in Allegan and Van Buren counties. Funds will also provide staff services on a contractual basis to the adjacent Jackson-Hillsdale-Lenawee area.

Anticipating that Congress will hold the line and that no funding of any new areawide CHP agencies or expansion of those already existing will be possible if Congress appropriates the same amount granted last year, federal officials are reviewing all existing budgets to insure the most effective use of available funds.

A proposed amendment is being studied by Congress which would permit state-level CHP commission to provide staff assistance to the areawide agencies not federally funded.

The Advisory Council was requested by the State Commission to develop recommendations to

encourage funding patterns to effectively support areawide planning agencies on an ongoing basis. Financial support, in addition to federal grants, has been drawn from sources such as: short-term federation grants, community united funds, county boards of supervisors and health departments, hospital contributions, contribution from professional societies, civic groups and industry.

Congress is also reviewing Section 314 (b) which would require appropriate representation on areawide planning agencies of practicing physicians, hospitals and other health care facilities.

The House-passed bill (HR 11102) would require a review by areawide comprehensive health planning agencies of applications for Hill-Burton



GOVERNMENTAL-MEDICAL CARE PROGRAMS

construction grants and loans now currently in effect but not now a statutory requirement.

* * *

New federal guidelines for health services developmental grants have the highest priority for funding under Section 314 (a) and would:

1. Focus on needs of individuals and families

rather than particular diseases;

2. Result in a continuum of environmental, physical and mental health services if necessary for the achievement of the highest level of health.

Participation by residents in the target areas in policy making and working roles are stressed.

The State Advisory Council approved formation of task forces to study the comprehensive personal health care, health manpower, costs and organization of services and an environment conducive to health. There was emphasis on the need for broader involvement of interested individuals (outside The Council) through participation and by presentation of position papers and statements.

Approval was also granted by The Council for the establishment of a Steering Committee, Committee on Policies and Procedures, and a Committee on Legislation.

(The preceding five articles were excerpted from Comprehensive Health Planning News, issue No. 4, June, 1969.)

Across The Nation

State Directors of Comprehensive Health Planning have formed the American Academy of Comprehensive Health Planning "To continually promote at all levels of society increased understanding of, strengthened appreciation for, and expanded involvement in comprehensive health planning for health."

* * *

Under the recent Public Health Service reorganization, the Office of Comprehensive Health Planning and the Division of Medical Care Administration have merged into the new Community Health Service.

(Source: Partnership for Health News, June, 1969.)

GOVERNMENTAL MEDICAL CARE PROGRAMS COMMITTEE ACTIVITIES

The newly re-structured and enlarged Committee undertook the following actions:

Comprehensive Health Planning

Reiterated the necessity and importance of physicians becoming thoroughly knowledgeable in order to be expert participants on all local and areawide advisory councils;

Recommended that The Council attempt by every available practical means to add articulate and well-informed practicing MDs on all local and state advisory councils;

Recognized the wide confusion of the relationship of the relationship between Hill-Burton and local/state advisory councils and decided to seek clarification from the appropriate agency;

Agreed that health facilities have the right to appeal rejected proposals and that there should be an appeal mechanism available at the local level.

Medicare-Medicaid

Agreed mandatory monthly visits by MDs to nursing homes (Title XIX) patients are unnecessary and burdensome and moved to inform The Council that a resolution will be presented at the 1969 House of Delegates to the effect that Title XIX patients should not fall under this enforced arbitrary rule and that the patient should be seen at the discretion of the physician;

Moved, in light of recent news releases concerning the unsubstantiated allegations and implications of abuse and fraud of physicians receiving \$25,000 a year or more under Medicaid, that The Council be advised that there is great concern about the manner in which this information is being used to the detriment of the medical profession;

Disapproved of the recertification requirement and moved to inform The Council it opposes recertification as unnecessary and strongly favored abolishing this requirement;

Was advised that a resolution will be introduced in the 1969 House of Delegates permitting a limited direct billing under Medicaid (Title XIX) to those who are not receiving cash benefits.

LOCAL CENTER STAFFS TO BE TRAINED AT U-M

University of Michigan School of Public Health has received a one year grant of \$54,685 from the Office of Economic Opportunity to train medical care administrators for neighborhood health centers throughout the country. Plans are being formulated to begin a series of institutes for persons currently employed in neighborhood health centers and to recruit and counsel students, primarily Negroes, to enter full-time training programs leaning toward administrative careers.

"MENTAL HEALTH BEDS" ARE ELIGIBLE FOR HILL-BURTON MONEY

The U.S. House Interstate Commerce Committee Report No. 91-262 on "Medical Facilities Construction and Modernization Amendments of 1969" states "That when Community Mental Health Center funds (P.L. 88-164) are unavailable, then Hill-Burton money 'CAN BE USED' for mental health beds (in either 'mental' or 'general' hospitals)."

This clarification was requested by NASMHPD to eliminate recurring confusion in the states over use of Hill-Burton money for mental hospitals.



Here's Wrap-up of Health-Related Actions Taken In First 1969 Legislative Session

Those interested may obtain copies of any new laws referred to in this article by writing to the Legal Affairs Committee, MSMS Headquarters, 120 W. Saginaw, East Lansing, 48823.

BY M. A. RILEY MSMS LEGISLATIVE COUNSEL

On August 5, Governor Milliken affixed his signature to HB 2196, authorizing one of Michigan's three universities which presently has a medical school to also add a college to teach osteopathy, and thus signed the last of many 1969 bills of substantial interest to Michigan's medical profession,

It had been a session lasting one week over six months, in which a new record high number of proposals had been offered. As is usually the case more than 10% of all bills introduced had either a direct or indirect impact on health. And as a consequence, MSMS' Legal Affairs Committee and Capitol staff took an active interest in over 200 separate measures during the six-month period.

DO COLLEGE BILL ALTERED

The "osteopathic college bill" finally approved by Governor Milliken bore little resemblance to proposals introduced in both the State Senate and House at the start of the session. It was in fact, the seventh revision of the original proposal which finally reached the Governor's desk.

Fairly early in legislative deliberations, the osteopathic hope for a separate and independent osteopathic college was dashed by insistence that any such teaching program be done as a part of the program of an existing college. Along with this change went the alterations in the bill eliminating

a separate college board of control, for which an "advisory council" was substituted.

Subsequent debate over the controversial issue resulted in the adding of a "dowry" in excess of \$300,000 to be appropriated to the existing university which accepted an osteopathic program; this was reduced to about \$225,000 before the bill went to the Governor and. since the newly authorized DO program will require considerable planning time, even the \$225,000 was eliminated leaving no attached funds for the 1969-1970 fis-

Finally, the bill (HB 2196) was changed again to provide language requiring that the osteopathic education program be carried out "on the existing campus" of a university having a medical school, thus apparently eliminating the possibility of creating unnecessary duplicative educational facilities at the Pontiac site preferred by the Michigan Osteopathic Association for its educational institution. And, in the final version of the bill, a requirement was added that the Dean of the Medical School (as well as the Dean of the new osteopathic school) be made exofficio members of the "osteopathic college advisory board."

Two final requirements of the new act must still be met before it becomes law in fact. First, the State Board of Education must select either Michigan State University, Wayne State University or the University of Michigan as the University it desires to have establish an osteopathic program. Second, the selected university must agree to accept this charge and develop a DO curriculum. Unless both events transpire the Legislative action is invalid. The Board of Education must designate a university within 90 days, or by the first week of November.

RESEARCH RECORDS MADE CONFIDENTIAL

The 1968 MSMS House of Delegates, in passing Resolution No. 31, requested passage of an amendment to the Michigan law to extend the benefits of Public Act 270 of 1967 to committees of county medical societies, specialty societies and MSMS itself. This was accomplished on August 6, 1969 when Governor Milliken signed Public Act 190 of 1969. The previous law, covering only records provided to in-hospital medical staff committees, was broadened to include any health facility or agency or committee. The law is permissive, saying that information or data may be released and no liability arises against the person or organization providing the information. In cases where records, etc., are furnished to county or state society committees the patients' name and address must be removed.

MSMS drafted the bill and guided it through a series of amendments in State Senate hearings, again presenting testimony in the House of Representatives, where the bill passed by a vote of 82 to 9. It becomes effective immediate-

MINOR CONSENT TO VD TREATMENT AUTHORIZED

Implementing Resolution No. 33 of the 1968 MSMS House of Delegates, the Michigan Legislature passed and sent to the Governor a new Michigan statute making valid and binding the consent of a minor to the provision of medical or surgical care of services by a hospital, public clinic or physician in connection with venereal disease. The law states that the physician may, but shall not be obligated to, inform a spouse, parent, custodian or guardian regarding the treatment given or needed, leaving this decision solely up to the physician even over the express refusal of the minor patient to the providing of the information. The bill was also supported in the Legislature by the Michigan Department of Public Health. It is Public Act 238 of 1969.

MEDICAL EXAMINER COVERAGE EXTENDED

A long-standing goal of the Michigan State Medical Society to extend the medical examiner system to all counties in Michigan was accomplished when Governor William Milliken signed Public Act 92 of 1969 on August 6. The bill was heavily supported by MSMS, which worked closely with the Michigan Funeral Directors Association in shaping certain amendments to the original draft as recommended by the Michigan Society of Pathologists. Under terms of the new law present coroners may complete the terms of office to which they have been elected, but following that period all counties shall appoint county medical examiners and two or more adjoining counties may enter into a common agreement to share a medical examiner. The law specifically provides that all medical examiners shall be physicians, and in counties with a population of 50,000 or more deputy examiners must also be physicians. The new law takes effect at once, as Public Act No. 92 of 1969.

UNIFORM ANATOMICAL GIFT ACT PASSED

With strong support and a lastminute push by MSMS, the House of Representatives acted on June 26 to pass Senate Bill No. 55, approved by the Senate in early April, and send to the Governor a bill which became Public Act 198 of 1969 to eliminate the legal-medical maze over human organ transplants in Michigan. The bill received the Governor's signature on August 6, bringing Michigan into line with some 20 States throughout the U.S. which have adopted this uniform law developed and approved by the A.M.A., American Bar Association and the Council on State Governments, MSMS had commenced working closely with the Michigan drafters of Senate Bill No. 55 in the early Fall of 1968.

ADDITIONAL MSMS-ENDORSED LEGISLATION NOW LAW

Governor Milliken signed Public Act 191 of 1969 on August 6, giving immediate effect to a new law eliminating the necessity for physical presence of a physician when public health nurses give immunization treatments. The treatment need only be provided under the physician's direction, thus markedly increasing the immunization program for the prevention of communicable diseases. MSMS gave strong support, presenting testimony in both the State Senate and House of Representatives.

With the endorsement of the MSMS Mental Health Committee, substantial support was given to House Bill 2953, which became Michigan law on May 20 as new Public Act No. 13 of 1969. This law gives statutory authority for the treatment of mental patients admitted to hospitals on emergency orders (prior to a final commitment order issued by a probate court). Its passage will enhance the delivery of psychiatric care in giving the right to appropriately treat patients under 48 hour or five-day detention orders.

MSMS was successful in having incorporated in House Bill 3315 (general amendments to jury provisions) language which will exempt doctors of medicine and doctors of osteopathy from jury duty. House Bill No. 2825 was originally introduced to accomplish this purpose and dropped in favor of adding a section to 3315, which finally passed the State Senate, with immediate effect, on July 16.

New Public Act No. 110 of 1969 amends the hospital act for mentally diseased persons to permit a psychiatric report from the hospital to which a patient has been temporarily admitted to be used by the probate court in place of the certification of two outside physicians. The language is permissive in nature, but should facilitate the commitment process.

MSMS also endorsed House Bill No. 3213 after consultation with the State Board of Registration in Medicine, and on July 21 this bill became Public Act No. 75 of 1969. It increases the fees charged to initial applicants for a license to practice medicine in Michigan from a former fee of \$30 to a new fee of \$75. The increased revenue will permit a changeover to the early use of the Federated Licensing Board Examination (FLEX), covering its purchase price and the cost of administration. A survey of other states indicates that an initial license fee of 75 dollars is near the current average, and the new type of examination is considered a significant improvement in gauging applicants from medical schools which are rapidly innovating new methods of physician training.

Simultaneously, House Bill 3214 had been offered for the purpose of raising the annual re-registration fee of doctors of medicine from a present \$5.00 per year to \$10.00 per year, since most reregistration fees were receiving similar percentage increases at the request of the State Department of Licensing and Regulation. MSMS agreed to the change, but efforts were made in the Legislature to increase the fee by amendment to as high as \$100.00 annually, with an annual reregistration fee of \$25.00 finally being placed upon the bill. Because of MSMS' demand that the \$10.00 figure be restored in line with action on other professional groups (Osteopathic fees, for example, went up to \$10.00) and the insistence of some Legislators that the \$25.00 figure be passed, HB 3214 was not acted upon at all but deferred until the October session for further consideration. As a result, MD reregistration fees currently remain at the five dollar figure!

MSMS supported House Bill No. 3378, which has now been signed by the Governor as Public Act No. 187 of 1969, and which authorizes Lafayette Clinic in Detroit to plan, establish and maintain and operate a "drug abuse center." The proposal had been highly endorsed by MSMS' Committee on Alcohol and Drug Dependence.

OTHER HEALTH LEGISLATION FOUND DESIRABLE BY MSMS

Additional bills passed by the 1969 State Legislature which were monitored and approved by MSMS included an act to license and regulate dealers and research facilities using dogs and cats for research facilities; amendments to the Michigan Pharmacy Act (prior to the passage of this bill, which is now Public Act No. 15 of 1969, amendments developed by MSMS were presented to the Michigan Pharmaceutical Association and accepted by them for incorporation); amendments to the ambulance licensing law to authorize cities, villages, charter townships and townships to contract for ambulance services and to assure that a trained attendant must accompany an ambulance at all times; and a new law which includes kidney machines within the meaning of prosthesis or prosthetic devices under provisions of the Social Welfare Act.

Public Act No. 100 of 1969 establishes a Muskegon State Home and Training School as an addition to Michigan's mental health institutions, and this bill was likewise enthusiastically supported by MSMS. An amendment, approved by the Michigan State Medical Society, was made to current law regulating the use of chemical agents which release toxic vapors, further restricting those substances which might be used for purposes of exciting, or dulling, the senses. The Legislature also approved, and MSMS had testified in support of, a new Michigan law to be known as the

"Critical Health Problems Education Act of 1969." This is Public Act 226 of 1969, which passed the Senate unanimously on July 9. It will promote the establishment of guidelines to teach both instructors and students in all schools a wide spectrum of subjects related to physical and mental health and safety.

STATE INSTITUTION SUPERINTENDENTS NEED NOT BE PHYSICIANS

Over the objections of MSMS, as recommended by the Society's Mental Health Committee, the Legislature has passed and sent to the Governor a bill which will authorize the Director of the Department of Mental Health to appoint superintendents of that agency's hospitals, state homes and training schools who are not physicians. The Department made this request, stating that it followed a pattern developing throughout the country, and that broadening the qualifications would substantially improve the recruitment market.

Since the osteopathic college proposal was substantially amended, before its passage, this mental health bill was the sole legislative offering in 1969 which cleared the legislative process despite MSMS' recommendation that it be significantly amended or deferred.

HEALTH OFFICERS IMMUNITY BILL VETOED

MSMS drafted, obtained introducers for and successfully moved to legislative passage Enrolled Senate Bill No. 560, introduced to protect public health officers from personal civil suits which might arise out of the course of their employment. Essentially the bill provided that the city, county or district would be required to pay the cost of legal defense and any judgment rendered when public health employees were defendants in suits resulting from the performance of their legal duties. A similar bill had been passed in 1969 (SB 522) providing like protection for law enforcement officers.

However, on July 28 the Governor vetoed SB 522 since it "singled out" a certain group of employees and made them immune from "personal liability." MSMS' bill was vetoed by the Governor a few days later. Public health officers presently run the risk of suit because of actions of their subordinates, not their own personal acts. A new approach to this vexing problem will be sought in the 1970 session.

MSMS LEGISLATIVE OFFERINGS POSTPONED UNTIL 1970 SESSION

Chief among the bills introduced at MSMS' request in 1969 and receiving preliminary consideration but not passage are the "Single Medical Practice Act" (Senate Bill No. 820) and the repeal of the Basic Science Law (House Bill No. 3098).

The Single Medical Practice Act, although it was introduced rather late in the 1969 session, was the subject of an intensive Senate Hearing and was retained by the Senate State Affairs Committee

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(Sen. Robert Huber, Chairman) for further study. Testimony was presented favoring adoption of the proposal by the Secretary of the Wisconsin Board, which licenses both MDs and DOs, and by several Michigan osteopathic physicians. Extremely vigorous opposition was expressed by the Michigan Association of Osteopathic Physicians and Surgeons: a Lansing osteopath, Dr. Ann Agustsson, who testified favoring adoption of the new licensing board was expelled from the Osteopathic Association shortly thereafter purportedly because she is a staff member of three medical hospitals in the Capitol city. Recent correspondence received from the licensing boards of Missouri, Iowa, Wisconsin, Ohio and Minnesota, all of which have both MDs and DOs on their boards, indicate that the single practice act concept is working well and to the satisfaction of osteopaths in those states.

The Basic Science repeal proposal reached the House of Representatives for a vote but fell just short of the required support to send it on to the Senate. It was then "tabled" and could be considered again in October only if 2/3 of the Representatives voted to suspend the rules to discuss the subject. Failing this action the bill must await the 1970 session for further consideration. MSMS has received very significant support and assistance in urging passage of HB 3098 from the Michigan Health Council.

MALPRACTICE LEGISLATION STILL PENDING

Four bills drafted and sponsored by MSMS to improve the malpractice insurance climate in Michigan received attention in appropriate committees during 1969 but failed to emerge for a vote in the State Senate. These bills were designed to (1) more precisely define the time the statute of limitations commences to run, (2) require a separate trial in advance on the question of the applicability of the statute of limitations; (3) require a \$500 plaintiff's bond as a deterrent to nuisance suits, and (4) permit insurance companies to make advance payments to their

insured without admitting liability. Under the rules and regulations of the Legislature, all are still eligible for further consideration and passage in 1970.

MSMS will also participate in the consideration, in 1970, of a proposed new Michigan law to license and regulate the practice of hypnosis. Testimony has been given on a number of occasions in connection with proposed legislation to liberalize Michigan's current abortion statutes, conveying to the Legislature the policy positions taken by the MSMS House of Delegates. Considerable attention is expected to be focused on the abortion legislation by the 1970 Legislature.

The 1969 MSMS House of Delegates directed vigilance to oppose any bills which would tend to "degrade" the practice of nursing. While no directly related bills appeared, MSMS successfully opposed a bill which would have bestowed a license without examination on practical nurses with five years of experience.

1970 SEEN A BIG YEAR FOR HEALTH LEGISLATION

Just as those bills desired by MSMS but not passed in 1969 are still eligible for passage in 1970, so are all those opposed by MSMS still under consideration. During the 1969 session, with a Republican majority in the State Senate and a Democratic majority in the House of Representatives, most bills introduced in one body were duplicated in the other. It was also not infrequent that a bill would be introduced early in the session and then introduced a second time later in the session. As a result, frequently an undesirable health bill would be found carrying four separate numbers and require attention in several separate legislative committees.

A total of well over 3,000 individual legislative offerings were brought to the 1969 Legislature and more than 2,500 of them *remain* before the 1970 session. To these will be added a potential 2,000 new, or resurrected, proposals, presaging the largest volume of legislation in 1970 to ever

come before the Michigan State Legislature.

SCORES OF UNDESIRABLE BILLS SIDETRACKED IN 1969

In Medigrams, articles in Michigan Medicine, and the News Extra throughout the period February to June it has been reported that an extremely large volume of proposed new legislation was rejected by the Michigan Legislature following MSMS presentations as to why the bills were not in the best health interests of the people of Michigan.

More than a dozen separate bills dealing with Michigan Medical Service and Michigan Hospital Service were held in committee: these proposals covered a variety of areas including control of the investment of funds, control of the corporations by the Public Service Commission, a demand that all state-licensed hospitals be automatically recognized by Blue Cross, and bills to give the State Insurance Commission substantially increased authority over Blue Shield fee schedules. Bills to exempt certain nursing homes from control by the Public Health Department, to require generic prescribing in all instances by physicians, to force Blue Cross and Blue Shield to fully recognize chiropractors as physicians, to make each physician pay \$3 for each laboratory service rendered by the Department of Public Health, and to exempt certain laboratories from the Laboratory Licensing Law were all rejected in 1969.

Additional bills opposed by MSMS and not acted upon by the Legislature would have exempted certain hospitals from the Hospital Licensing Law, required physicians to report all disabilities of their patients which might affect their ability to operate a motor vehicle (but not provide appropriate immunity for so reporting), give sweeping authority to the Director of Public Health to control distribution of vaccines, and place the Comprehensive Health Council and Advisory Council under law (an action deemed premature by MSMS in 1969).



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The page can be detached easily by folding the journal flat and then pulling the page down to remove.

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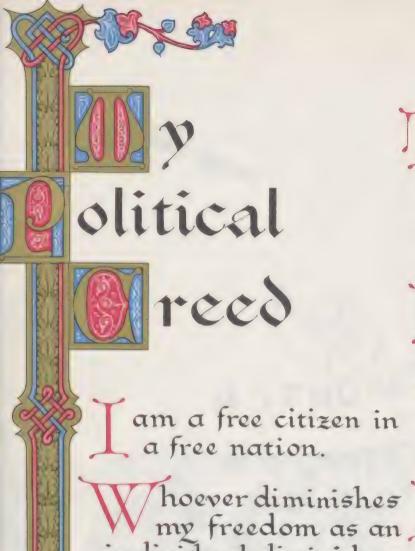


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in my country.

am also a physician, free thus far to treat, my patients to the best of my ability.

bridge that freedom and the health of my patients is adversely affected.

hese things being true, I cannot -- I will not-stand idly by when these hard-won freedoms are under attack.

or I believe that the values upon which this country was founded are immutable and have not been eroded by the passage of years.

hoever diminishes | believe that I, as a my freedom as an I free citizen in a free individual diminishes land, am obligated to defend my beliefs in the ways permitted to me, and required of me, by our form of government.

> herefore, let no man seek to bar me from the political process; for it would be akin to denying my right to participate in the process that determines free government.









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Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: Central Nervous System—
Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. Autonomic Nervous System—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. Endocrine System—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. Skin—Dermatitis and skin eruptions of the urticarial type, photosensitivity. Cardiovascular System—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine) While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. Other—A single case described as parotid swelling.

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NEWS BRIEFS

SIDNEY A. BECKWITH, M.D., STOCKBRIDGE,

has retired after 34 years of practice and was honored by 400 townspeople at a special Sunday afternoon program in Stockbridge. The Beckwiths have purchased a home in Crested Butte, Colo., where they plan to reside. He is former chief of Foote Hospital, Jackson, and has practiced in Newfoundland and at Jackson's Southern Michigan State Prison.

G. REX BULLEN, M.D., JACKSON,

was honored by a reception recently marking his 50 years as a practicing physician. Hosts were his three children. Doctor Bullen was a trustee of the Jackson County Sanatorium and is a member of the Tuberculosis Association, the Jackson County Medical Society and the staffs of Mercy and Foote Hospitals in Jackson.

JOHN W. BUNTING, M.D., ALPENA,

a former delegate to the MSMS House of Representatives, retired from active practice during the summer because of ill health.

ROBERT W. CORLEY, M.D., JACKSON,

was honored at a surprise dinner party given by the Jackson County Heart Unit volunteers at Arbor Hills Country Club. Immediate past unit president, Doctor Corley was presented with a plaque of appreciation from the Michigan Heart Association. During his term of office the Jackson unit opened a Heart Information Center for the public.

JOSEPH FOUST, M.D., IONIA,

is on a year's leave of absence as the Ionia County health director to pursue a master's degree in public health at the University of Michigan. B. P. Brown, M.D., Barry-Eaton health director, is covering Ionia as a consultant.

ALBERT C. FURSTENBERG, M.D., ANN ARBOR,

former dean for 24 years of the University of Michigan Medical School, has been recognized with the naming of a scholarship fund in his honor. The fund, set up by a Southfield man whose life was saved by Doctor Furstenberg, is to be used to aid medical students specializing in the field of Otolaryngology at the U-M or Wayne State University.

GORDON R. HARROD, M.D., GRAND LEDGE,

has been elected treasurer of the Grand Ledge Board of Education.

ARTHUR B. HENDERSON, M.D., DETROIT,

has been named Distinguished Physician of the Year by the Detroit Medical Society. He was named at the society's 12th annual Clinic Day luncheon.

S. FRANKLIN HOROWITZ, M.D., BAY CITY,

is new chief of staff at Bay City General Hospital. He began work at his new post on July 1.

E. J. KLOPP, JR., M.D., BATTLE CREEK,

is new president of the Michigan Thoracic Society. He succeeds Robert A. Green, M.D., Ann Arbor, associate dean of the University of Michigan School of Medicine. The Thoracic Society is affiliated with the Michigan TB and Respiratory Disease Association.

DANIEL LANDRON, M.D., MICHIGAN CENTER,

has ended 23 years of private practice to become director of the emergency room staff at Foote Hospital, Jackson. He is one of 14 area doctors to form a corporation to provide the hospital emergency room with around-the-clock medical care for the first time.

JOSEPH R. LENTINI, M.D., GRAND RAPIDS,

is Grand Rapids Lion of the Year, so named by the Grand Rapids Lions Club for his many civic and professional activities. Among them are past president of the Kent County Medical Society and Board of General Practitioners; former director of the American Cancer Society. He is a member of the Michigan Health Council, and the Ethics Committee of the Michigan Association of the Professions.

WALTER L. LYNN, M.D., BAY CITY,

has been named an associate medical director of Winthrop Laboratories, a division of Sterling Drug, Inc.

MICHIGAN GOVERNOR WILLIAM G. MILLIKEN

has appointed John H. Kitchel, M.D., Grand Haven, as a member of the Michigan Water Resources Commission and re-appointed Stuart M. Finch, M.D., of Ann Arbor, to the Michigan Mental Health Advisory Council.

DON W. PROUD, M.D., BAY CITY,

has been elected president of the Mid-Michigan Psychologists Corporation. He is chief psychologist with the Bay City Child Guidance Clinic.

JOHN L. SHIELDS, M.D., FLINT,

has discontinued private practice to take over the post of Director of Medical Education at McLaren General Hospital, Flint, Doctor Shields opened his new office on Aug. 1. He is a diplomate of the American Board of Internal Medicine, and a member of the Michigan Society of Internal Medicine.

JOHN T. SYDNOR, M.D., DETROIT,

was the subject of a feature story in the *Michigan Chronicle*, Detroit, which lauded his success in life. "I am proud to practice medicine," he was quoted as saying. "I get a great feeling of satisfaction from helping the unfortunate with time and money."

HARRY A. TOWSLEY, M.D., ANN ARBOR,

received a Michigan United Fund Founders' Award at the recent MUF Annual Meeting. He is the third to receive the award and was cited for his many years of dedication to the cause of giving, for MUF leadership and for deep insight and tireless efforts to bring to the people of Michigan the best in health programs.

J. C. WEBSTER, M.D., MARLETTE,

was presented recently with a plaque by the local Lions Club in honor of his more than 50 years of practice in Marlette. Doctor Webster was the guest of honor at a dinner arranged by the Lions Club.



Doctor Hoobler

Doctor Hoobler Modern Medicine's Cover Subject

Sibley W. Hoobler, M.D., professor of internal medicine at University of Michigan Medical School and director of the University Hospital's Hypertension Unit, is the cover story subject in the July 14 issue of *Modern Medicine*.

Doctor Hoobler, selected by the medical journal editors as their "contemporary" for the July 14 issue, is cited as a hypertension expert of international reputation.

He has been director of the hypertension unit—one of the first of its kind in the world—at University Hospital since its founding in 1947. Among his current activities are selection of premedical students for participation in an undergraduate cardiovascular training program, sponsored by a grant from the National Institutes of Health, and direction of a 10-clinic investigation of hypertension and stroke, involving medical schools across the nation.

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EXTENTABS

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming). BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. Contraindications: Hypersensitivity to barbiturates or sympathomimetics; patients with advanced

renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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(A 16-m.m. sound color film on Brighton Hospital is available for free loan to qualified groups.)



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MAO inhibitors.

Precautions: Use with caution in patients hyper-sensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological by unstable individuals may result in a psychologic dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.

Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.

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Dexamyl brand of dextroamphetamine sulfate and amobarbital brand of sustained release capsules

curbs appetite encourages normal activity dispels diet discouragement

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Michigan's Emergency Room Doctors Cite Many Advantages to Incorporation

BY JUDITH MARR MANAGING EDITOR Michigan physicians who have incorporated to provide emergency room care in local hospitals are quick to cite many advantages about the arrangement.

The object, regardless of how the corporation is organized, is to provide medical coverage of the emergency room 24 hours a day, 365 days per year.

Its major advantages, according to John G. Wiegenstein, M.D., Lansing, whose enthusiasm has inspired him to organize the national American College of Emergency Physicians, are in:

- 1. Providing standardization of quality of emergency care;
- 2. Providing standardization of fees for emergency room doctors' services;
- 3. Allowing specialists who participate parttime in emergency room activities to maintain levels of proficiency in other levels of medicine, and
- 4. Assuring, from the patient's standpoint, a standard level of care, standard fees and confidence in the physicians who will treat them.

Other Michigan physicians, who have organized local emergency room corporations, ascribe even more advantages to incorporation.

PHYSICIANS INTERESTED, DEDICATED

The value of the corporation is excellent, says John van de Leuv, M.D., Oxford. "These men are interested in emergency service or they wouldn't work in it. They are therefore more dedicated than the physician who is appointed for work on a rotating basis."

Members in the corporation earn extra money and the arrangement can be really "a godsend" for someone just starting out in practice, adds Doctor van de Leuv, who is president of the Physicians Emergency Care Group of Pontiac, P.C.

"Our only other choice besides incorporation here was to rotate one doctor on emergency room call each week," he says. "Seventy-five percent of the local physicians wouldn't take part under that basis, so we thought volunteers taking over on a fee-for-service basis would go over best."

In Pontiac, 24 part-time emergency physicians take between two and six eight-hour shifts per month in the emergency room. Doctor van de Leuv is the only one on a salary; other board members are paid a fee for meeting monthly. The entire group meets quarterly.

In Ann Arbor, where five physicians work fulltime through the Washtenaw Physicians Emergency Service, P.C., at St. Joseph Mercy Hospital, waiting time for emergency room patients has been cut to 30 minutes from the previous three hours they had to spend before receiving aid.

The change is due to the corporation, according to President Robert S. Ideson, II, M.D. He also

credits the doctors' company with dropping the number of admissions to the hospital from the emergency room by 300 cases in a year.

"The five of us have 21 years' average experience in previous private practice," explains Doctor Ideson. "We are better able to diagnose and to suggest that a patient may return home with good prospects of recovery than were the interns that used to staff the emergency room. They were more frantic and admitted more persons to the hospital."

Family physicians, assured of the good treatment their patients are getting in the emergency room, now request that they be consulted only when the emergency physicians deem it necessary, says Doctor Ideson. "They're tickled. They get to sleep through a night," he adds.

ON FEE-FOR-SERVICE BASIS

The Ann Arbor doctors do their own billing on a fee-for-service basis, using the relative value scale approved by MSMS. Most Michigan emergency room doctors follow a similar arrangement.

The subject of finances brings to mind another advantage in emergency room corporations, says Peter Duhamel, M.D., Rochester, president of the Rochester Physicians Emergency Service, P.C.

"There are much greater tax advantages and fringe benefits in the professional corporation," he notes.

But more than that, the Rochester corporation has engendered good will within the community, he says, as townspeople are assured they will receive competent and prompt treatment and that their own private physician will be informed of their case.

A bonus for the Rochester organization has come through its membership of 19 MDs and seven DOs. "Our group in particular has helped knock down any of the barriers to communication between the MDs and DOs on the mixed staff of Crittenton Hospital," boasts Doctor Duhamel.

EMERGENCY SERVICE IMPROVED

Both Doctors Ideson of Ann Arbor and van de Leuv of Pontiac explain that their organizations were formed because of the expansion of emergency room services and because the local doctors felt previous service — provided mostly by interns — had been inadequate.

"We were showing the greenest doctors into a job where the most experience was needed," comments Doctor Ideson, whose St. Joseph Mercy Hospital has seen a jump from less than 3,000 emergency cases in 1945 to over 30,000 in 1968.

"Service was poor and slow at Pontiac's St. Joseph Hospital," says Doctor van de Leuv. "Patients coming to the emergency room to see their own physicians had a long wait and then often were seen by the house staff instead.

EMERGENCY PHYSICIANS/Continued



"The borderline emergency cases in particular got very poor treatment," he continues. "They often had to rely on doctors just out of medical school and received no follow-up care or recommendation." The same reasons — better care faster for standard fees — are compelling doctors to incorporate for emergency room service across the nation, interjects Doctor Weigenstein.

SPECIALTY REFERRAL COMMON

If emergency room patients at Pontiac's St. Joseph Hospital must be admitted to the hospital,

the emergency physicians are under strict orders to contact the patient's physician, that he may select his own specialist.

Likewise, when patients at Ann Arbor's St. Joseph Mercy Hospital require a specialist, emergency physicians there are limited to giving X-rays, first aid and preventing shock. The patients' own physicians ask to be called in if they are needed.

And at Rochester, according to Doctor Duhamel, cases requiring admission or specialist referral are referred through the patient's own physician (if he is on the staff) or to the hospital staff man on call for that specialty. There the emergency physicians provide only initial diagnosis and treatment.

"It looks like the emergency room corporation is the going thing," comments Doctor Ideson. "Our staff is solidly behind us now, even those who were at first reluctant."

"Very encouraging," says Doctor Duhamel of the future of such corporations.

Doctor van de Leuv predicts that most of the part-time groups will become smaller organizations of full-time emergency physicians. "Probably the best coverage would be given by full-time specialists, much as I hate to admit it," says the part-time emergency room physician.

"The emergency room corporation's services probably will expand," he continues. "I believe the group will follow the patient all the way through his treatment, with follow-up provided by the emergency physicians or his colleagues in the group."

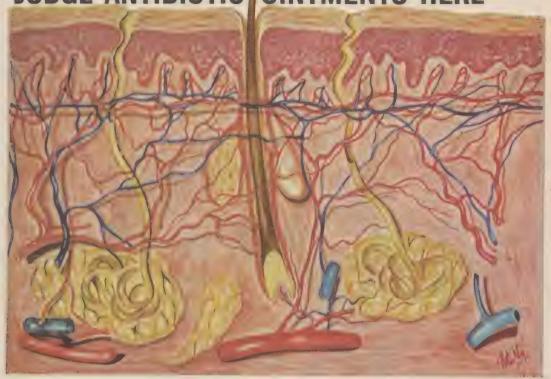
MICHIGAN EMERGENCY PHYSICIANS

According to Doctor Wiegenstein, approximately 700 incorporated Michigan doctors are providing emergency room service, either on a full-time basis in staffs of about four per hospital, or on a part-time basis, which requires approximately 24 physicians, per hospital, working in shifts.

About 180 of those 700 are members of the new American College of Emergency Physicians, Doctor Wiegenstein reports. A major project of the new ACEP is to set up between nine and 15 regional model emergency room corporations to serve as centers of information and examples of ideal arrangements for interested area doctors.

Other emergency room corporations in Michigan are the MD Emergency Service of Livonia, P.C., led by John T. Rogers, M.D.; Genesee County Out-Patient Association, P.C., Robert J. Rathburn, M.D., Flint; Emergency Physicians Incorporated, P.C., Grand Rapids, John A. Rupke, M.D.; Ingham Emergency Physicians, P.C., John G. Wiegenstein, M.D., and the Jackson Emergency Medical Care, Inc., Frank J. Schrader, M.D.

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Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

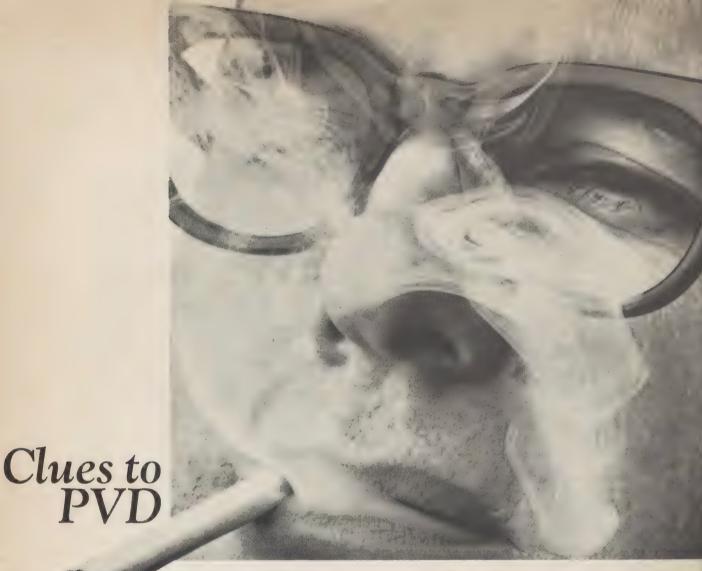
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He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

Thus, a history of heavy smoking coupled with vasospasm may serve as warning signals to the physician. When a diagnosis is established, therapeutic measures are directed toward increasing the local circulation, and appropriate management of the patient's general medical needs should be instituted. These include the important safeguards of keeping warm and refraining from smoking.

Before prescribing Roniacol Timespan (nicotinyl alcohol tartrate), please consult complete product information, a summary of which follows.

Indications: Conditions associated with deficient circulation; e.g., peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets morning and night.

How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50.



Important in total management of peripheral vascular disease, vascular spasm or chilblains Roniacol Timespan (nicotinyl alcohol tartrate) for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.

Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.

Selectivity of action—relaxes the musculature of peripheral blood vessels.

High degree of safety—side effects seldom require discontinuation of therapy.



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Preludin often puts a curb on appetite and promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

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Preludin phenmetrazine hydrochloride

Endurets® prolonged-action tablets

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A number of factors must come together in the right proportions at the right time and in the right place to produce a vibrant center of economic activity and growth.

Detroit is just such a center of strength. And it will continue to maintain that great strength to assure significant economic stability and advance-

ment.

The population trend for the Detroit Metropolitan Area indicates substantial increases for the foreseeable future. Since the census count of 1960 the area has registered a 10% increase — the population currently is 4,214,000. The prediction is for about 4,800,000 by 1975 and 5,300,000 by 1980.

Detroit is a city of 140 square miles in a metro-

politan area of 2,000 square miles.

At an altitude of 581 feet above sea level, its mean temperatures vary between 26.2 degrees in January and 73.1 degrees in July. The annual average is 49.3 degrees.

AMERICAN CENTER

Detroit's favorable, centralized location in mid-America has contributed to its becoming an internationally recognized convention center.

Detroit is the mid-western access point to some of America's most scenic and historic settings.

Constantine Doxiadis, called the "world's greatest master planner," has predicted that Detroit may well become the "center of gravity" of a 600-mile area encompassing Milwaukee, Toronto, Pittsburgh, Buffalo, Cleveland and Chicago.

The Great Lakes region is America's fastest growing population area. Future growth will be so spectacular that the area—with Detroit as the Great Lakes Megalopolis—will have a greater population than the eastern United States in the beginning of the 21st century.

The relationship between Detroit's market population and the age distribution within that num-

ber provides a powerful potential both for the service and consumer goods industries. Currently, 19.3% of Detroit's area population is in the 10-19 year old group; 37% are 20-49 years old. One-third of the Metropolitan area population is less than 15 years of age; only 8% is over 65.

Available consumer spendable income and the willingness to make judicious use of that income

are the marks of a good retailing area.

The Detroit Metropolitan Area consistently remains among the top five sectors in the nation on both counts. In fact most of the time Detroit leads the list or is vying for the top spot as the best retailing center in America.

ECONOMIC STRENGTH

The fact that there are more than 29,000 retailers in Detroit testifies to the economic strength of the City. So does the existence of 20,000 service establishments. And 6,000 wholesalers. And 6,000 manufacturers.

Average consumer spendable income per household in Detroit is \$11,023; nearly \$2,000 above

national average!

Retail sales per household average nearly 60% of spendable income. Total retail sales reach \$7 billion annually; wholesaling, \$8 billion. Detroit area families annually spend 9% more than the United States average -21% more for general merchandise: 43% more for drugs; 35% more for automobiles. The annual food bill for Detroiters exceeds \$1.5 billion.

While retaining a strong retail market in the downtown-core area, Greater Detroit in the past 10 years has experienced the growth of a giant network of neighborhood and outlying shopping centers and plazas.

Among the raw materials vital to the development of an economy are money and credit.

Detroit has ample supplies of both.

Portrait of a Great City - Detroit, Scene Of MSMS Annual Session

Michigan physicians and wives, who attend the annual MSMS and Woman's Auxiliary sessions in Detroit during the week of September 28 will enjoy the many improvements made to the downtown area. The city-county building, with its noted sculpture, has helped to set the pace for the attractive new business buildings and landscaping.



Some of the factors which have contributed to Detroit's rank of *fourth* among the nation's great banking centers are:

- ★ Aggressive advertising
- ★ Imaginative innovations in checking account methods
- ★ Financially attractive plans for both longand short-term personal savings
- ★ Sincere involvement by banking personnel in civic affairs
- ★ Close cooperation with all sectors of the business community
- ★ An atmosphere of mutual respect with Detroit's citizens

The labor force of Metropolitan Detroit currently averages above 1.5 million employed with an annual income of \$12 billion.

Though Detroit is still pridefully the "automobile capital of the world," less than 18% of the work force is employed in the manufacture of motor vehicles and equipment.

Non-manufacturing employment accounts for 46% of Detroit's working population.

Among the 14 most populous American cities, Detroit ranks first in its percentage of workers employed in wealth-producing industries and in value added by manufacturing per employee.

Detroit's rising employment figures are not just the result of population increases. Quite the contrary, increased employment has resulted directly from the creation of new jobs in an expanding Detroit economy.

Detroit ranks as a leader among cities in the nation.

CONVENTION CENTER

Of growing importance to large urban areas is the "industry without smokestacks" – convention facilities.

Detroit has the largest and finest convention/ exposition center in the world, the \$55 million Cobo Hall with 2.2 million square feet of floor space.

Detroit offers hospitality, courtesy and excellent service to its guests.

Accredited hotel/motel facilities include 18,000 rooms with price ranges to suit all budgets and tastes. From 1964 to 1967, \$20 million of new hotel/motel construction was completed. Several projects are currently underway—involving new construction, remodeling and renovation.

"Research and development" is a familiar phrase in Detroit. This is so because Detroit, the home of automation, is also the home of research for a wide variety of products and processes. Some 61 separate research facilities are located in Greater Detroit—exclusive of public and private universities.

The areas of industrial and basic research with which Detroit is most involved include: chemicals,

electronics, metal working, general engineering, automotive, fluid and solid mechanics, pharmaceuticals, general medicine, life processes, automation and nucleonics. And this is by no means a complete list of Detroit's total research activity.

Currently being planned, for example, is a 66-acre Research Park, involving an eventual capital investment of nearly \$300 million, which will be located in close proximity to Wayne State University and Detroit's Medical Center.

ONE THOUSAND Ph.D.s

There are more than 1,000 Ph.D.s working in basic research, applied research and management in Detroit.

Detroit-based companies spend over \$600 million a year in advertising revenue. Reliable estimates place Detroit third among American cities in advertising expenditures.

The two major Detroit dailies have a combined average daily and Sunday circulation of 1,310,000 in the metropolitan and outstate areas. Suburban dailies, trade journals and neighborhood weeklies augment the news readership and advertising market of the two major metropolitan papers.

Detroit has six local television channels and nine major AM and 11 FM radio stations.

In the Detroit metropolitan area there are 54 institutions of higher learning. Among them are the University of Detroit, one of America's largest Catholic universities; University of Michigan, recognized as one of the great universities of the world and Wayne State University, located in the heart of Detroit and one of the most rapidly expanding universities in America.

The Detroit Public School System encompasses 340 schools, including six vocational trade schools.

Detroit can boast one of the finest utilities systems of the world.

The Detroit Edison Company supplies service to 1.5 million customers in a 7,600 square mile area in Detroit and Southeastern Michigan. Detroit Edison has a capability of four million kilowatts. An additional exchange capacity of 800,000 kilowatts is available through interconnections with neighboring electrical power systems.

Michigan Consolidated Gas Company serves nearly a million industrial, commercial and residential customers in 350 communities. The company recently located its offices in a magnificent \$20 million building in Detroit's Civic Center.

The Michigan Bell Telephone system serves three million telephones and handles eight million phone calls per day. Significantly, the percentage increase in the number of telephones in use in the Detroit area has averaged in recent years above the general rate of increase for the entire Bell System.

OUTSTANDING HIGHWAYS

Over Detroit's and Michigan's outstanding system of surface roads and freeways 200 motor truck carriers, supplemented by more than 130,000 pri-

vately owned trucks, transport goods to every part of the United States and Canada.

As an extension of the east-west highway routes, six Lake Michigan ferries carry trucks directly to Wisconsin and subsequently to all points west, bypassing the bottlenecks of marshalling yards.

The International Bridge at Sault Ste. Marie in Michigan's Upper Peninsula is a rapid link to all Canada.

All highways in Detroit and Michigan are tollfree.

The International Bridge and the Mackinac Bridge, which connects Michigan's two peninsulas, do charge toll fees.

SEAPORT LINK

Detroit's port links the City with 201 seaports around the world.

The Detroit River today handles well over 100 million tons of traffic a year, making it the world's busiest inland waterway.

Shipping and terminal facilities at the Port of Detroit have demonstrated a consistent pattern of growth and improvement since 1958.

Overseas vessel calls to Detroit have increased to just under a thousand per shipping season. Regularly scheduled service betwen Detroit and most of the other ports of the world is provided by 48 lines from 21 countries.

Michigan is the second most important Customs District in the United States. Much of the total customs collections is accounted for by the activities of the Port of Detroit.

Direct economic benefits to the Detroit community from the activities of the Port currently amount to just under \$40 million per year.

The \$100 million Detroit Metropolitan Airport, only 35 minutes by expressway from any point in the metropolitan area, is serviced by 16 major foreign and domestic airlines. Detroit "Metro" averages 1,050 daily takeoffs and landings — of which 766 are passenger flights; the remainder are cargo and military movements.

Number of air passengers accommodated has now reached 4.2 million per year including 150,000 clearing customs. Air cargo exceeds 400 million pounds per year.

Detroit City Airport, only ten minutes from downtown is used by both private and corporate plans and by four commuter airlines. In fact, it is the busiest airport in Michigan in terms of the number of aircraft movements.

Three downtown railroad terminals in Detroit are served by nine prime rail lines which move annually 24 million tons of cargo in and out of Detroit. Five of these lines offer passenger service. All provide first-class freight service to the Detroit industrial complex. Railroad tunnels at Detroit and Port Huron, Michigan, provide a short rail route to Canada and the industrial northeastern United States.

Since the end of World War II well over \$350 million has been spent on construction of 43 miles of a modern freeway network within Detroit, a system second in size only to that of Los Angeles.

Two of these freeways, the John C. Lodge and the Edsel Ford, support annual vehicle travel of 850 million miles.

When Detroit's interstate freeway program is completed in 1975, there will be 65 miles of freeways within the City, built at a cost of \$668 million.

CULTURAL PERSONALITY

What city, except for New York, sells the most legitimate theater tickets in the United States? Detroit holds that distinction.

Generally considered to be primarily an industrial giant, Detroit has a vibrant cultural personality which is often overlooked.

The Detroit Institute of Arts in Detroit's Cultural Center offers one of the finest art collections in the nation.

Fort Wayne is now for the history buff the best preserved pre-Civil War fort in Midwest America.

The Detroit Historical Museum and the Dossin Great Lakes Museum round out the land and sea histories of Detroit with their exhibits and models of Detroit as it was.

Known throughout the world, the Henry Ford Museum and Greenfield Village present a panorama of the complete scope of American History.

The Detroit Public Library, headquartered in a magnificent Main Library in Detroit's Cultural Center, has 28 branch libraries throughout Detroit.

COSTS LESS

It costs less to live in Detroit than in virtually any other major American city.

In a comparative listing of cost of living in fourteen major metropolitan centers and the national average, Detroit is near the bottom of the list. Annual cost of living for a moderate-income family of four in Detroit is \$8,981 compared to an average of \$9,188 for the entire United States.

Only in two of the cities compared is housing less expensive than in Detroit. The average Detroiter, for example, spends \$2,076 per year on housing. In Boston, the figure is \$2,732.

In no other city on the list does a citizen pay less in taxes than in Detroit. The Detroit tax figure is \$1,250. In Milwaukee it is \$1,693. In New York, \$1,645.

Slightly below the U.S. average for annual medical care expenditures, Detroit ranks sixth among the 14 cities surveyed.

With an annual personal income of \$12 billion—with average consumer spendable income per household nearly \$2,000 above national average—Detroiters have more dollars to buy more goods and services of a more varied nature than most other American urban dwellers.

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Milk-free, hypo-allergenic Soyalac has a pleasing taste that is eagerly accepted by most infants. It's similar to mother's milk in composition and assimilation, much like cow's milk in consistency and completely free of fibre. Extensive clinical data support Soyalac's value in promoting growth and development. Soyalac is also excellent for growing children and adults.

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DON'T WANT YOU TO WORRY,
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SHOULD DO IT...
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other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving



WE'VE GOT TO GET
PLENTY OF REST AND
TRY TO AVOID SITUATIONS
THAT MAKE US ANXIOUS
OR TENSE. AND WE'LL
TAKE MEDICINE TO LOWER
OUR BLOOD PRESSURE
AND CALM US DOWN.



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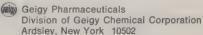
corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight

gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. <u>Average Dosage</u>: One tablet daily with breakfast. <u>Availability</u>: Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-C

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These Firms Planning Colorful, Educational Exhibits at Annual Session

Michigan physicians attending the 1969 MSMS Annual Session Sept. 28-Oct. 2 at the Sheraton-Cadillac Hotel in Detroit will be treated to colorful and educational exhibits planned by 67 firms.

The companies, state-wide to international in scope, will showcase techniques and products ranging from complicated laboratory equipment to baby food and all pertinent to a doctor's practice.

MSMS leaders urge annual session-goers to take time to inspect each exhibit — not just a quick look — but a real indepth study, for it is surprising the wealth of new information the booths offer.

Income from the leasing of exhibit space makes it possible for MSMS to present its excellent Annual Scientific Session without a registration fee.

Special intermission periods especially designated for exhibit-viewing will be provided between Annual Session meetings and lectures. The registration desk, meeting rooms and exhibits will be conveniently located on the same floor as the meetings.

MSMS also wishes to express its gratitude to those who have generously made program grants to the Annual Session. These contributors are:

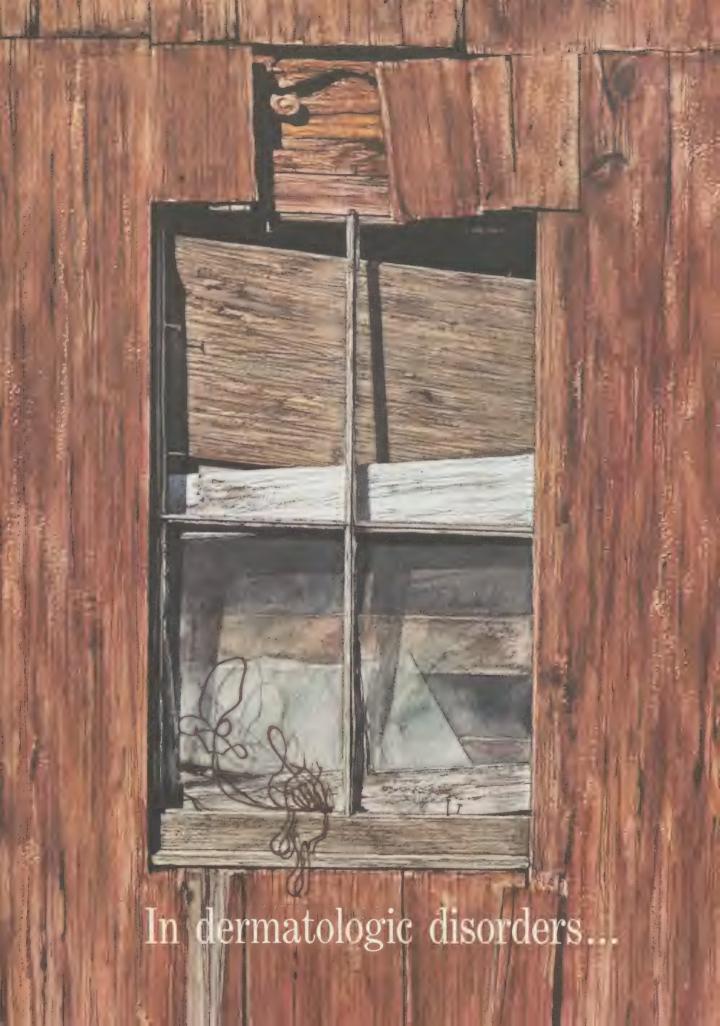
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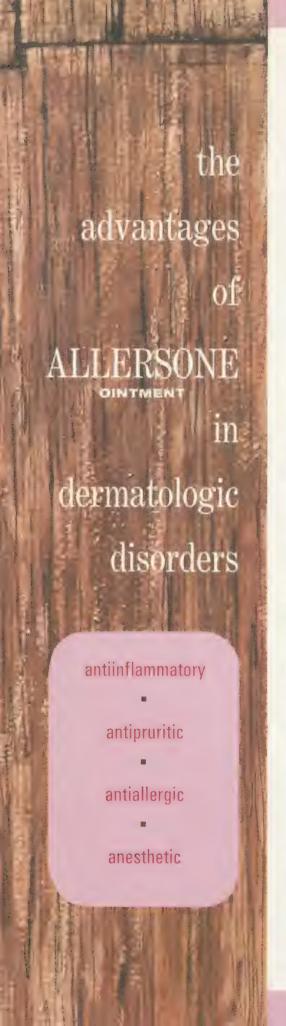
Following is a list of the firms who will be presenting displays. Doctors are urged to make a special effort to visit each booth to personally express appreciation and to ask questions.

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INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

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CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain —while hydrocortisone reduces inflammation—in a water-washable vehicle —no desquamation from fats.

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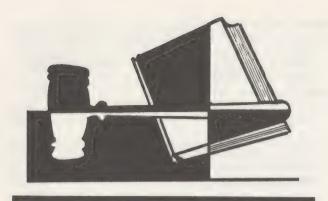
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LEGAL

(Editor's Note: The following articles are quoted from the AMA CITATION newsletters of June 1, and June 15, 1969 respectively, prepared by the AMA Law Department.)

NEW TRIAL IN HOSPITAL BURN CASE

A patient who sustained severe burns while hospitalized for treatment of a stroke that had partially paralyzed him was granted a new trial in his suit against the hospital. Although the patient presented no direct evidence that the hospital was negligent, there was evidence from which a jury could infer that there was negligence on the hospital's part, a Michigan appellate court ruled.

As a result of the stroke, the patient was partially paralyzed on his right side and could not move his right arm. Three days after his admission to the hospital, the right side of his body became burned. The patient testified that he did not recall the cause of the injury and offered no evidence of the cause. The transcript showed that he

was unable "to testify normally."

The reviewing court said that the trial court's direction of a verdict for the hospital, because of the patient's failure to present direct evidence of the hospital's negligence, was improper. Pictures showed that the patient sustained severe burns over a large portion of his paralyzed right thigh, buttock, and arm, and the right side of his back. Burns of the severity and extent of those sustained by the patient do not ordinarily occur to a hospital patient unless someone has been negligent. It would thus have been neither speculative nor conjectural for the jury to have concluded from the injury and the circumstances thereof that it was caused by someone's negligence.

The patient was allowed visitors and it was possible that his injury was caused by someone other than a hospital employee. However, the absence of exclusive control does not necessarily preclude an inference of negligence in a case such as this.

The patient proved all that he could have been expected to prove. In view of his condition, it was entirely understandable that his injury could have

been sustained without his either being aware that it was occurring or recalling at trial the cause of its occurrence. The hospital was required to counter the permissible inference that the patient's injury was caused by its negligence by coming forward with an explanation of the cause of injury which would persuade the trier of fact not to draw the inference or which would so overcome the inference that the court would conclude that it would no longer be reasonable for the trier of fact to draw the inference. — Hand v. Park Community Hospital, 165N.W.2d 673 (Mich., Nov. 29, 1968)

CLAIM AGAINST HOSPITAL BARRED BY CHARITABLE IMMUNITY

A patient's claim against a hospital was barred by the doctrine of charitable immunity, a Michigan appellate court ruled. The patient suffered pain, numbness, and paralysis of the left leg and foot, allegedly as the result of a student nurse's negligent administration of an injection in her buttock. The nurse's negligence, if any, occurred before the effective date of Michigan's abrogation of the doctrine of charitable immunity. The patient's claim that the hospital's hiring of the student nurse and permitting her to administer injections constituted administrative negligence remains to be passed on by a trial court.

In Parker v. Port Huron Hospital, 105N.W.2d 1 (THE CITATION, Vol. 3, No. 5, p. 22), the immunity of charitable institutions for the negligent acts of its employees was prospectively abolished. The effective date of the decision was September 15, 1960. The decision made clear that the applicability depended on the date of the accrual

of the cause of action.

The injection was given in May, 1960, and the patient was discharged from the hospital in June, 1960. The fact that the patient was treated as late as January, 1961, by the same physician who attended her at the hospital did not establish that her cause of action did not accrue until after September 15, 1960. The statute of limitations provides that a cause of action accrues at the time of the wrongful act, regardless of the time when damages result.

The evidence supported the finding that the hospital was a charitable institution. Its articles of incorporation provide that it is to be operated exclusively for charitable, scientific, and educational purposes. The land on which it stands is subject to a restrictive covenant that it is to be used solely for public hospital purposes. The hospital has been granted exemption from taxation by several taxing bodies. Over a period of years the dollar value of free medical care rendered by the hospital exceeded its net operating income by a substantial amount. The hospital is to a considerable extent dependent on donations. — Cibor v. Oakwood Hospital, 165 N.W.2d 326 (Mich., Oct. 24, 1968)

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Visit us in Booth #206 at the Annual Session in Detroit, October 1-2

M.D. PAC Calls For Involvement Of Detroit Doctors

A call to 2,900 Detroit-area physicians to become politically active has been issued by six Wayne County members of the state board of directors of the Michigan Doctors Political Action Committee (M.D.PAC).

The six, who are Louis R. Zako, M.D., Allen Park; Frederick W. Engstrom, M.D., Dearborn, and Frank B. Bicknell, M.D., Alexander Blain, III, M.D., William O. Mays, M.D., George L. Reno, M.D., all of Detroit, sent letters recently urging 2,900 Detroit-area doctors to join M.D.PAC.

"We believe that it is vitally important to our profession for Detroit-area doctors to take an active part in our political processes," they wrote.

"Recent events emphasize that the future of American medicine lies in the political arena, as well as in the research laboratory. M.D.PAC believes in active participation in our democratic political process, not in passive criticism, and in seeking sound and imaginative solutions to major problems.

"We strongly feel that Michigan doctors are concerned about our nation's future and that what is good for our patients is good for the medical profession. We face a tremendous challenge to help shape our society's future for the better, through the intelligent exercise of public responsibility."



ANCILLARY SECTION

Careersmobile Travels Along

The Michigan Health Council's Health Careersmobile has been touring Michigan cities throughout the summer, where the most common stops have been the county fairs. Its schedule during August and dates already set this fall include:

Aug. 1-10 Ionia Free Fair

Aug. 13-14 Lapeer Days, Lapeer

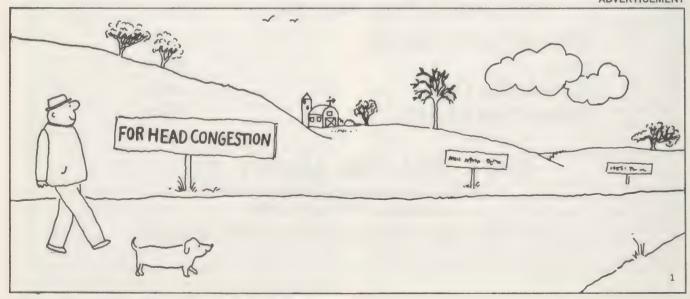
Aug. 18-23 Calhoun County Fair, Midland

Sept. 7-13 Allegan County Fair

Sept. 21-26 Hillsdale

Oct. 20-25 Flint

ADVERTISEMENT



HEART ASSOCIATION OFFERS FREE MATERIALS TO PHYSICIANS

Michigan physicians interested in literature on stroke may make use of these publications available free of charge from the Michigan Heart Association:

Modern Concepts of Cerebrovascular Disease, a

bi-monthly publication;

"Diagnosis and Management of Stroke," a 32page booklet by James F. Toole, M.D., chairman, Department of Neurology, Bowman Gray School of Medicine;

Publications and Visual Aids, a catalog;

The Desk Reference Cards, a terse reference guide printed on 4 by 6 file cards and also published in the March and April issues of *Michigan Medicine*.

"Hypertension: The Challenge of Diagnosis," a 20-minute color-sound film produced by the American Heart Association.

In addition, the MHA has available a 20-minute color-sound film produced by the American Heart Association, titled "Hypertension: The Challenge of Diagnosis;" Desk Reference Cards on Rheumatic Fever, prepared and revised by MHA's Rheumatic Fever Committee, containing terse but complete outlines of Jones Criteria, diagnosis and therapy, and three new volumes issued in the Association's Monograph Series, titled, Cardiovascular Surgery, 1967, Cooperative Study on Cardiac Catherization, and Diagrammatic Portrayal of Variations in Cardiac Structure.

Postgrad Topic: Nuclear Medicine

The American College of Physicians will present a postgraduate course on "Nuclear Medicine: Diagnosis and Treatment of Disease with Radionuclides Given Internally," Nov. 3-7 at the University of Michigan Medical Center. William H. Beierwaltes, M.D., will be director.

Dean Hunt Formally Acknowledges MSU Appropriations

In a formal statement following legislative authorization for Michigan State University to plan a full medical degree-granting program, Dean Andrew D. Hunt, Jr., M.D., of the MSU College of Human Medicine has expressed his appreciation.

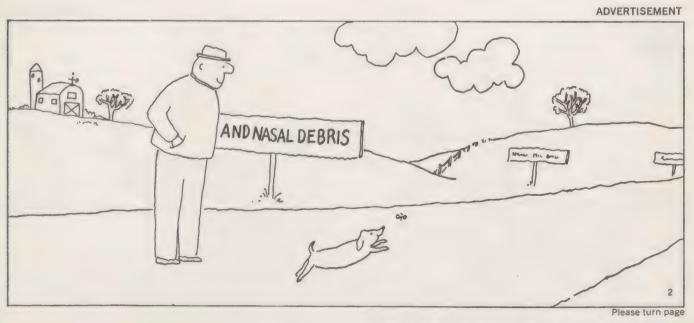
"The authorization to plan the third and fourth years of our medical program will enable us to work toward the development of a total center for education in medicine and the other health professions," said Dean Hunt.

"We appreciate the confidence that has been expressed by the legislature, the governor and the State Board of Education," he said, "and we shall regard it as a mandate to develop a medical school that will be truly responsive to the health needs of the state.

"We expect to develop innovative new ways of educating doctors that will practice in Michigan, to continue our research in the basic medical sciences, and to develop new methods of providing improved health care to more people."

DOCTOR BAUER SUCCEEDS DOCTOR MEYER

WSU Dean Ernest Gardner has announced the appointment of Raymond B. Bauer, M.D., as acting chairman of the Department of Neurology, beginning Sept. 1. Doctor Bauer was named to fill the vacancy created by the resignation of John Stirling Meyer, M.D., who is leaving WSU to become chairman of the Neurology Department at Baylor University, as well as chief of the Neurology Departments at Methodist and Ben Taub Hospitals in Houston.



SAMA CHAPTERS SEND THANKS

Student American Medical Association chapters at Michigan State University and The University of Michigan have responded to MSMS contributions to their treasuries.

Writes Joel Morganroth, SAMA president at the U. of M., "The University of Michigan SAMA Chapter would like to thank you for your generous contribution to our finances. The money will be used to send our delegates to the Regional and National SAMA Conventions."

And from Ronald Tokar, president at MSU. comes this note: "On behalf of the MSU Chapter of SAMA, I would like to thank the Michigan State Medical Society for its generous contribution to our chapter. In the past this money has been used to send delegates to the Chapter President's Conference and to the National Convention of SAMA. Last year some funds were appropriated to the Regional SAMA Convention which took place here in East Lansing. Thank you for your generous help."

New MSMAS Officers To Learn at Workshop

"Prelude - An Introductory" is the title of a workshop for new officers and chairmen of the Michigan State Medical Assistants Society scheduled Sept. 13-14 at Kingsley Inn, Bloomfield Hills. The know-how of duties and responsibilities will be explained. Tila Lenz, Oakland County Medical Assistants Society president, is chairman.

PLAN COMPLETED FOR FEDERAL HELP TO RETARDATION FACILITIES

Completion of a revised plan for federally assisted construction and staffing of community mental retardation facilities has been announced by William H. Anderson, M.D., direction, Michigan Department of Mental Health.

The plan is required by the federal government in order for Michigan to qualify for certain federal construction and staffing funds.

A total of \$440,252 in federal funds is currently available for construction of Michigan retardation facilities. Federal funds are granted for projects which include diagnostic, treatment, education, training, custodial and sheltered workshop services, with projects combining the most of these services receiving top priority.

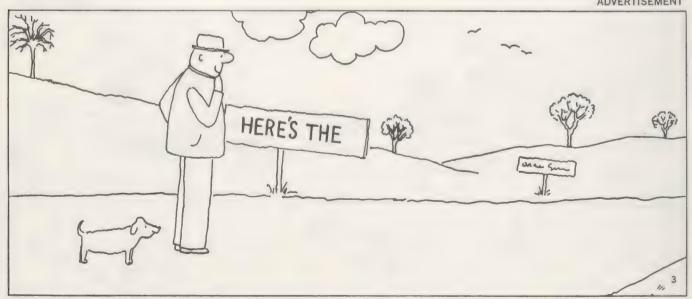
Copies of the plan are available for inspection from the Michigan Department of Mental Health, Program Development Division, Lewis Cass Building, Lansing.

HEALTH DEPARTMENT STATISTICS NOW UNDER TWO WINGS

Because of the scope and technical character of the workload, the Center for Health Statistics in the state health department has been divided into two wings.

The operations wing will be headed by Ted Ervin, acting chief, who will supervise departmental work in vital records, statistics, and data processing. The research and development activities in the Center will be headed by Robert Lewis, Ph.D., and include Project ECHO and the coordinated data processing and analysis program for the Michigan Regional Medical Program.

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Doctor Tanay's Theories Receive Wide Notice

The Detroit News recently covered a talk by MSMS member Emanuel Tanay, M.D., Detroit, in which Doctor Tanay reported there is a new "frequency and hostility" in "Dear John" letters sent to servicemen in Vietnam.

Doctor Tanay, who visited Vietnam in January, is an associate professor of psychiatry at Wayne State University. He theorizes that the lack of patriotism at home during this particular war makes it easy for women to withdraw their love and support of the men overseas in relatively greater numbers.

The Detroit News, picking up Doctor Tanay's remarks at a Detroit meeting of the Interprofessional Association on Marriage, Families and Divorce, turned them into a feature article. The story was carried by the wire services world-wide in newspapers, on radio and television and Doctor Tanay has since received numerous letters and telephone calls.

Pharmacy Prescription Rules Tightened

Confidentiality provisions of newly enacted amendments to the Michigan Pharmacy Act prohibit pharmacists from allowing detailmen or medical sales representatives access to prescription files.

Also under Section 18 of the Pharmacy Act, a pharmacist receiving a prescription copy cannot dispense the drug until obtaining an original (written or telephoned) prescription from the physician.

SAMPLE MEDICAL FORMS AVAILABLE TO DOCTORS

A Bronxville, N.Y. firm, V. W. Eimicke Associates, Inc., is offering free samples of its new doctor-created medical forms to any interested physicians.

The forms include a manila file envelope with blanks on the outside for major points in each patient's medical history, plus separate sheets labelled admission/summary/release, consultation request and report, electrocardiogram, tissue examination, transfusion record, progress monitor, patient monitor, pulmonary history and diagnosis, diabetic progress, cardiac history and progress, renal history and progress, history and general physical examination.

Address of the Eimicke Co. is 914 Deerfield, Bronxville, N.Y., 10708.

Three MDs Appointed At U-M School Of Public Health

Three personnel changes have been announced for the University of Michigan School of Public Health. Accepting the recommendations of Dean Myron E. Wegman and Allan F. Smith, vice president for academic affairs, the Regents have named Harold J. Magnuson, M.D., associate dean; Fred M. Davenport, M.D., chairman of the department of epidemiology, and Bertram D. Dinman, M.D., acting department chairman and acting director of the Institute of Industrial Health.



MICHIGAN MEDICINE SEPTEMBER 1969 993



IN MEMORIAM

Addison B. Aldrich, M.D. Hancock

Addison Broan Aldrich, M.D., Hancock general practitioner, died June 20 at the age of 60.

Doctor Aldrich was a graduate of the University of Michigan Medical School and was affiliated with St. Joseph's Medical Center in Hancock. He was a former president and secretary of the Houghton-Baraga-Keweenaw Counties Medical Society.

Karl A. Anderson, M.D. Grand Rapids

Karl A. Anderson, M.D., retired Grand Rapids physician, died June 21 at the age of 79.

Doctor Anderson was a graduate of the State University of Illinois Medical School and was affiliated with Blodgett Memorial Hospital in Grand Rapids. He also served on the staff of the Michigan Veterans Facility there.

He was a past president of the Eaton County Medical Society and had also served on the staff of the Kalamazoo State Hospital.

Ronald M. Athay, M.D. Eloise

Ronald Milton Athay, M.D., retired physician who practiced in Detroit 23 years, died July 1 at the age of 80 at his retirement home in Eloise.

Doctor Athay was a graduate of the Northwestern University School of Medicine and was a former member of the American Psychiatric Association and the American College of Hospital Administrators.

He was a former member of the Wayne State University pediatrics faculty, former medical director of the Wayne County Department of Social Welfare and superintendent of the Wayne County General Hospital and Infirmary. He was also a former diagnostician with the Detroit Board of Health, former medical director of the Detroit Committee on Alcoholism Clinic and medical director of the Midland County Committee on Alcoholism.

Allen B. Bower, M.D. Armada

Allen Blake Bower, M.D., former president of the Macomb County Medical Society, died July 19 at the age of 77.

Doctor Bower was former chief of staff at St. Joseph's Hospital, Mt. Clemens, and was a life member of the AMA. He was graduated from the Detroit College of Medicine and Surgery and was also affiliated with the Almont Community Hospital.



E. Walter Hall, M.D. Detroit

E. Walter Hall, M.D., former Detroit radiologist for 43 years, died July 3 at the age of 75.

Doctor Hall was on the staffs of both Harper and Crittenton hospitals in Detroit and retired in 1958 from a radiological partnership. He was a graduate of the University of Michigan Medical School.

Doctor Hall was past president of the Detroit Roentgen Ray and Radium Society, a fellow of the American College of Radiology and a member of the American Roentgen Ray Society.

Lloyd C. Harvie, M.D. Saginaw

Lloyd C. Harvie, M.D., Saginaw physician for

50 years, died July 5 at the age of 79.

Doctor Harvie was a fellow of the American College of Surgeons and a past president of the Saginaw County Medical Society. He was graduated from the Detroit College of Medicine and Surgery and served as Saginaw County's Red Cross director during World War II.

He was affiliated with Saginaw General Hospital and St. Luke's and St. Mary's Hospitals in Saginaw. He had served on the MSMS State Ethics Committee and specialized in ophthalmology.

Arthur Isaacson, M.D. Detroit

Arthur Isaacson, M.D., retired Detroit physician,

died July 18 at the age of 76

Doctor Isaacson was a native of Russia and was graduated from the University of Toronto School of Medicine, He was a private practitioner until 1965 when he became associated with the Detroit Industrial Clinic, He retired in 1967,

Doctor Isaacson was a life member of the AMA,

and served as medical advisor to Selective Service Board No. 91 since 1940,

Lien-Fu Lo, M.D. Birmingham

Lien-Fu Lo, M.D., of Birmingham, Detroit hematologist, died July 20 at the age of 45.

Doctor Lo was a graduate of the University of Oregon Medical School and was affiliated with Metropolitan Hospital in Detroit. He specialized in internal medicine.

Walter L. Merz, M.D. Owosso

Walter L. Merz, M.D., Owosso physician for 24

years, died July 14 at the age of 61.

Doctor Merz was on the staff of Owosso Memorial Hospital and was medical director of the Pleasant View Medical Care Facility there. He had been medical examiner for the Ann Arbor Railroad for 20 years and was graduated from the University of Michigan Medical School.

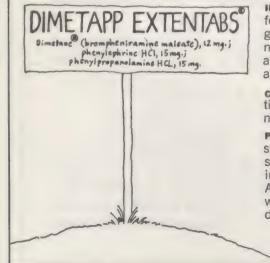
Norbert T. Pasternacki, M.D. Detroit

Norbert T. Pasternacki, M.D., chief of staff at Lakeside General Hospital, Detroit, died July 13 at the age of 64.

He was instrumental in organizing the Lakeside General staff in 1950 and had served as chief of staff since then.

Doctor Pasternacki, a graduate of Harvard College school of Medicine, was staff secretary of Holy Cross Hospital in Detroit. He was a general practitioner and a member of the American, Michigan and Wayne County Academies of General Practitioners and the American Geriatrical Society.

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PONOTES & QUOTES 99

BY HERB AUER, EXECUTIVE EDITOR

Physicians can read an editorial that appeared in a recent Editor and Publisher and see how they would react to the suggestions. The editorial in the professional journal for newspapermen asks whether the editors are well informed or not — by making these

suggestions:

"Take a black leader to lunch in the ghetto . . . attend a city council meeting . . . go for a walk in the inner city . . . strike up a conversation with the filling station attendant . . . become involved in the social revolution . . . read all the mail to the editor . . . browse the newsstands and see the dirty literature . . . look, listen, question . . . keep your eyes and your mind open."

The guest column in the current issue of the Michigan United Fund Newsletter is written by MSMS President James J. Lightbody, M.D., as the medical director of the Arthritis Foundation, Michigan Chapter. He credits MUF for its "generous support" to make possible a research program in rheumatic diseases for the past 18 years. Doctor Lightbody writes the Michigan Chapter "research program has been acclaimed one of the best scientific activities in the country."

"What kind of member are you?"

That question has been asked many times in appeals for members to become more active.

Arch N. Booth, executive vice president of the Chamber of Commerce of the United States, classes some members into four categories— "Checkbook Members," "Prestige Members," "Coattail Members" and "Chronic Joiners," and then makes an appeal for more people to be "Practical Members." He observes that the "practical

members provide the voluntary leadership which has become such a vital force in dealing with the chaotic conditions around us to-day."

For a good definition of "public affairs" we will quote from a recent speech by Joe D. Miller, director of the AMA Division of Public Affairs. Mr. Miller said: "Public Affairs is a systematic effort to safeguard an organization's rights and fulfill its responsibili-



ties to the community while encouraging individual members of the organization to safeguard their own rights and fulfill their own responsibilities."

A new organization has been started in Ann Arbor, according to Elmer White, executive secretary of the Michigan Press Association. The organization is called "The Society for the Emancipation of the American Male" with a purpose "to restore the American patriarchy and thus return men to their positions as heads of their families." Mr. White reports that the organization already has the support of — a woman's auxiliary!

"The hospital must increase its efforts to be responsive to the needs of the community as a whole, as well as to its individual patients," declared the keynoter at the recent Hutzel Hospital centennial program. The speaker, Robert E. Tranquada, M.D., med-

ical director and associate dean of the Los Angeles County-University of Southern California Medical School, continued: "The hospital can no longer play a role which is self-determined by those with a direct interest only in the welfare of a single institution, no matter how well-meaning they may be. The health care and related needs of the urban community are too great and the potential costs are too overwhelming to allow that limited role to continue."

Author Raymond Squires in a recent issue of the national PTA Magazine surveyed all TV commercials for several days while recovering from surgery and wrote: "As a nation we are in terrible physical condition. Our dentures are loose, our hearts burn, our stomachs growl protestingly, our heads ache, our feet itch, our dandruff falls in blizzards. And besides, we don't smell very nice."

A challenge that "Michigan hospital people develop a strong, unified public relations front in all statements regarding hospital effectiveness and costs" is contained in the booklet, "The Public Relations Aspects of Hospital Effectiveness" published by the Michigan Hospital Association. The publication points out that many of the "flat charges, guesses and unsubstantiated stories regarding hospital costs and effectiveness . . . gain credence because they conform with the things that many people want to believe." The booklet suggests ways to "halt the rising wave of misrepresentations, unfounded charges, distorted facts and outright fabrications concerning the influences forcing hospital costs upward."

Everyone chuckles when he finds errors in newspapers and magazines. Can you find the errors in these excerpts:

The Youth Decency Rally was kicked off by the American Legion rum and bugle corps. (Jackson, Tenn., Sun)

An 89-year old man, who asked that he not be named, said he had loved in the neighborhood all his life. (St. Louis Post-Dispatch)

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

MICHIGAN STATE MEDICAL SOCIETY JOURNAL

Michigan Medicine

SEPTEMBER 1969 • VOLUME 69 • NUMBER 18

PARTICIPATE IN THE 1969 MSMS ANNUAL SCIENTIFIC SESSION IN DETROIT, OCTOBER 1-2

MSMS President James J. Lightbody Invites New and Young Physicians To Annual Session

New MSMS members and young physicians from throughout the state are especially invited to attend the Michigan State Medical Society's Annual Session scheduled Sept. 28-Oct. 2 at the Sheraton-Cadillac Hotel, Detroit.

Extending the invitation is James J. Lightbody, M.D., Detroit, MSMS president, who also points out that the Annual Session is one of the services members of MSMS receive on paying their dues. There is no registration fee and no charge for attendance at the Annual Session, Doctor Lightbody emphasizes.

"The meeting this year is being tuned to the times and there will be prominent, authoritative speakers on many current medical subjects," he continues, welcoming all physicians to the meeting. "The committee has incorporated sufficient diversity of subjects for presentation so there will be something of interest to attract every physician and his wife in the state to attend some portion of this convention."

The master calendar of events for the 1969 Annual Session calls for the Annual House of Delegates meetings beginning Sunday evening, Sept. 28, and concluding Tuesday evening, Sept. 30.

On Wednesday and Thursday, Oct. 1 and 2, the Annual Scientific Sessions will be held, with a variety of speakers discussing medical subjects and issues all day, both days. Running concurrently with the Scientific Sessions will be four all-day Postgraduate Courses at the nearby Statler Hilton Hotel, and the first State Society Dinner Dance is scheduled Wednesday evening, Oct. 1.

During their two-and-a-half day meeting, the MSMS House of Delegates will elect and install new officers; bestow honors on 50-year members, on Michigan doctors who serve as presidents of national medical associations and on those who



Doctor Lightbody

have served voluntarily in Vietnam. They also will recognize a Michigan Physician of the Year.

The Annual Scientific Sessions will include general sessions on Surgically Correctable Forms of Hypertension, Subcutaneous Mastectomy with Prosthetic Reconstruction, Neurologic Problems in Children, The Efficient Use of Blood and Blood Components, Oxygen, The Relationship of Maternal Nutrition to Fetal Development, Septic Abortion with Endotoxin Shock, Burns and Hiatus Hernia

The Postgraduate Courses, designed for indepth study by physicians, will take up the subjects of Cardiovascular Pharmacotherapy, Medical and Surgical Emergencies, Nephrology Now and Office Orthopedics.

Program chairman for the 1969 Annual Session is Alexander J. Walt, M.D., Detroit, while H. A. Towsley, M.D., Ann Arbor, is chairman of the Friendship Committee.

ANNUAL SESSION SPEAKERS





G. C. Cotzias, M.D.

Roger H. Unger, M.D.

George C. Cotzias, M.D., Brookhaven National Laboratory, Associted Universities, Inc., Long Island, and Roger H. Unger, M.D., associate professor of internal medicine, The University of Texas Southwestern Medical School, and Director of Research, Veterans Administration Hospital, will both speak on Thursday afternoon, Oct. 2, during the annual Scientific Session of the Michigan State Medical Society, Sheraton-Cadillac Hotel, Detroit.

Ann Arbor, Detroit Schedule Major Health Week Observances

The Michigan observance of Community Health Week Oct. 19-25 will be highlighted by two large gatherings in Ann Arbor and Detroit.

On Monday, Oct. 20, a Community Health Week Program, featuring an appearance by Michigan Gov. William G. Milliken, is scheduled all day at the Towsley Center for Continuing Medical Education, The University of Michigan.

On Thursday, Oct. 23, the emphasis of the state observance will shift to Detroit, for a day-long program entitled "Health Manpower for Southeastern Michigan" aimed primarily at high school guidance counselors.

The Ann Arbor program, designed as a Community Health Week kick-off, will include a welcome by Robert Mason, M.D., Birmingham, 1969-70 MSMS president; an address by a national speaker on health manpower, tours of University Hospital, the U-M Hospital centennial year observance and remarks by U-M President Robben Fleming.

Over 100 high school guidance counselors will be invited to the Detroit program at Providence Hospital, in keeping with the Michigan emphasis on attracting the state's youth to health careers during Community Health Week.

The counselors will be given the opportunity to meet and plan programs with state health professionals and become acquainted with health care opportunities for youth. The program will be hosted by leaders in the health professions from throughout southeastern Michigan.

U-M Medical Alumni Reunion Sept. 26-27

Developments during the last century in medical school curricula will be reviewed for alumni of the University of Michigan Medical Center at their annual reunion Sept. 26-27 at the Towsley Center for Continuing Medical Education, Ann Arbor.

The morning program Sept. 27 will center around the theme "1869-1969: Medical Curriculum and University Hospital." Moderator will be William N. Hubbard, Jr., M.D., dean of the U-M School of Medicine. Speakers outlining the early medical school history will be Harry A. Towsley, M.D., director of Postgraduate Medical Education at the U-M, and members of the U-M School of Medicine Class of 1919.

MSMS Scheduling Fall PG Courses

Plans are being completed for 15-20 fall postgraduate programs across the state, under the sponsorship of the MSMS Committee on Postgraduate Medical Education.

The MSMS Council acted at its summer meeting to change the format of the community programs, adopting the recommendations of the MSMS committee.

The Committee and Council have decided that MSMS would no longer provide speakers for county medical society meetings, but would provide one or two university medical educators for an afternoon hospital clinic-seminar type of program. The visiting faculty member would discuss patients at the wet clinic with the local physicians, and also would be available for an evening speech.

The schedule of locations, subjects and speakers is being developed by PG Chairman H. A. Towsley, M.D., and Neal Vanselow, M.D., coordinator for the fall series.

SECOND ANNUAL SEX ED WORKSHOP SCHEDULED OCT. 23

The Lay Education Subcommittee of the MSMS Maternal Health Committee is planning its second annual Sex Education Workshop for Michigan physicians on Oct. 23 at MSMS Headquarters, East Lansing.

The all-day meeting will present a program of discussions of existing sex education programs in the public schools that have come under fire. Attempts will be made to see what can be done to counteract the recent outbursts by parents against the school programs.

The committee, headed by Richard T. Mellis, M.D., Kalamazoo, Lay Education subcommittee chairman, hopes to have on the program representatives of five or six school districts that have encountered public controversy over their sex education classes.

"MSMS has been in favor of family life and sex education classes in public schools," notes Doctor Mellis. "Through this workshop we hope to stimulate and educate physicians to help their local school districts."

Councilor Conferences In Progress

The annual series of District Councilor Conferences is now in progress preceding the annual MSMS House of Delegates meeting which will be Sept. 28-30 at the Sheraton-Cadillac Hotel, Detroit.

The First District Detroit Councilors are holding their own series of several meetings. Following is the list of dates and places for the outstate district conferences:

2nd District — Sept. 4, Jackson
3rd District — Aug. 26, Battle Creek
4th District — Sept. 4, Cassopolis
5th District — Sept. 2, Grand Rapids
6th District — Aug. 19, Flint
7th District — Sept. 16, Port Huron
8th District — Sept. 10, Saginaw
9th District — Sept. 17, Cadillac
10th District — Sept. 18, Bay City
11th District — Sept. 3, Fremont
12th and 13th Districts — Sept. 10, Iron
Mountain
14th District — Sept. 2, Ann Arbor
15th District — Aug. 21, Mt. Clemens

Blue Shield Requests Rate Increase

Michigan Blue Shield has asked the Michigan Insurance Bureau to approve a 16.7 percent rate increase for the first quarter of 1970.

The first rate hike sought by Blue Shield since 1963 would raise the average combined Blue Cross-Blue Shield monthly rate by 5.6 percent. In announcing the proposed rate increase Aug. 30, Blue Shield President John C. McCabe said that it was impossible for Blue Shield to further resist "the continuing inflationary pressures common to our total economy."

Blue Cross proposed no change other than "minor adjustments" in its base rate. It did file a request for a two percent rate cut for about 370,000 holders of Blue Cross 65. The Blue Shield rate hike would affect approximately 14 percent of nearly five million members during the first quarter of 1970.

Mr. McCabe estimated that under the Michigan Variable Fee program, the average rate adjustment would mean an increase of 45 cents a month for a single person, \$2.10 for a couple and \$2.43 for a family.

'Where We Stand' Third Revision Released

The third annual revision of "Where We Stand," a current analysis of the position of medicine and some of its problems in Michigan, has been completed and sent to MSMS delegates and county medical society officers.

Prepared by the MSMS Research and Development Department, the revision was authorized by the 1968 House of Delegates. The MSMS Publication Committee has praised the new edition as a "workbook" and "suggestion book."

Study and Save Legislative Summary

MSMS members are urged to study and save from the September issue of Michigan Medicine the complete wrapup of health-related actions taken in the first 1969 legislative session of the Michigan House and Senate. Including concise summaries of such important bills as the Single Medical Practice Act and the DO College Bill, the article outlines the course of about 25 proposals through the legislature. Valuable as a reference tool and a reminder of the status of legislation of interest to MSMS, the roundup, prepared by MSMS Legislative Counsel M. A. Riley, should be read by every Michigan doctor.

SEVEN 1969 NAT'L PRESIDENT AWARDS SET

Each year the Michigan State Medical Society at its Annual Session presents awards to Michigan physicians who are serving as presidents of national medical organizations. This year seven Michigan doctors will receive awards Tuesday afternoon, Sept. 30, before the 1969 MSMS House of Delegates meeting at the Sheraton-Cadillac Hotel, Detroit.

The doctors and the organizations they serve include Duane L. Block, M.D., Dearborn, Industrial Medical Association; James Ferguson, M.D., Grand Rapids, the American Proctologic Society; Donald J. Jaffar, Southfield, American Urological Association; Clarence S. Livingood, Grosse Pointe, American Dermatological Association; Raymond W. Waggoner, Ann Arbor, the American Psychiatric Association; William B. Weil, Jr., M.D., East Lansing, the Society for Pediatric Research, and Chris J. D. Zarafonetis, Ann Arbor, the American Society of Clinical Pharmacology and Chemotherapy and the American Therapeutic Society.







Doctor Vincent

Doctor Howard To Appear Before Delegates

Ernest B. Howard, M.D., executive vice president of the American Medical Association, will bring greetings from the AMA to the opening meeting Sunday, Sept. 28, of the 1969 MSMS House of Delegates' annual session.

Doctor Howard's remarks will come early in the opening evening dinner session of the House, following remarks by the MSMS Speaker of the House, James B. Blodgett, M.D., Detroit.

Dector Howard's talk will precede the farewell address by outgoing president of MSMS, James J. Lightbody, M.D., Detroit, the president-elect's address by Robert J. Mason, M.D., Birmingham, and special awards ceremonies.

Doctor Howard has held his AMA position since March, 1969 and has been with the AMA since 1948 when he was appointed Assistant General Manager. He holds his M.D. degree from Boston University Medical School and a M.P.H. degree from Harvard University.

Luncheon Topics To Be Students, Black Doctors

The viewpoints of the medical student and the Black physician will be shared at General Luncheons Wednesday and Thursday, Oct. 1 and 2, with Michigan doctors who attend the 1969 MSMS Scientific Session at the Sheraton-Cadillac Hotel, Detroit.

"The Black Physician and His Search for Talent" is the title of the talk to be given at the Wednesday noon general luncheon by Charles C. Vincent, M.D., Detreit.

Bruce Fagel, national treasurer of the Student American Medical Association, a student at the University of Illinois College of Medicine, Chicago, has been invited to address the Thursday noon General Luncheon.

Doctor Vincent is an assistant professor of obstetrics-gynecology at Wayne State University School of Medicine, where he serves as a member of the Admissions and Recruitment of Minority Group Students committees.

VERY HIGH PERCENT OF PHYSICIANS RESPOND TO POSTGRAD SURVEY

A very high 88 percent of 1,600 randomly selected Michigan physicians have returned completed questionnaires studying their postgraduate educational needs.

The high return rate is reported by Anthony Riley of the Center of Research for the Utilization of Scientific Knowledge (CRUSK), at The University of Michigan, which has conducted the study authorized and granted by the Michigan Association for Regional Medical Programs.

According to Mr. Riley, who is co-director of the study with Neal A. Vanselow, M.D., Ann Arbor, the center is beginning its analysis of the survey and plans to release the first rough results sometime in October.

The detailed and lengthy questionnaire was mailed in mid-March to approximately one of every six medical doctors in Michigan, with hopes that it would aid medical societies and schools in formulating future plans regarding medical education.

According to Doctor Vanselow, the purposes of the study are to find what physicians' attitudes are toward the postgraduate educational materials offered in Michigan from the universities and MSMS, to discover what the physicians would like to have offered in the future that is not available now, and to define the pressures from work, families and finances that prevent some physicians from keeping up.

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